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# OVERSIGHT HEARING ON TITLE III, OLDER AMERICANS ACT, AND EFFECTS OF MEDICARE'S DRG IMPLEMENTATION

## HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

## COMMITTEE ON EDUCATION AND LABOR
## HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

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HEARING HELD IN WASHINGTON, DC, JULY 30, 1985

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# OVERSIGHT HEARING ON TITLE III, OLDER AMERICANS ACT, AND EFFECTS OF MEDICARE'S DRG IMPLEMENTATION

TUESDAY, JULY 30, 1985

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON EDUCATION AND LABOR,
*Washington, DC.*

The subcommittee met, pursuant to call, at 10 a.m., in room 2257, Rayburn House Office Building, Hon. Dale E. Kildee (chairman of the subcommittee) presiding.

Members present: Representatives Kildee and Tauke.

Also present: Representative Biaggi.

Staff present: Susan A. Wilhelm, staff director; Gertrude L. Wright, legislative associate; Thomas Kelley, clerk; and Carol Lamb, Republican legislative associate.

Mr. KILDEE. The Subcommittee on Human Resources meets this morning for the purpose of examining the effects of changes in Medicare's hospital reimbursement policies on the demand for services provided under title III of the Older Americans Act.

While we will be considering this issue as it relates to the Older Americans Act, we cannot ignore the greater issues involved. Those issues are these questions: Are older Americans the losers in terms of quality medical care and humane treatment? Are savings in health care showing up as increases in other programs? Are Medicare patients coming home quicker and sicker only to find that they cannot find the help they need? And, finally, if there is evidence of older Americans losing ground under this system, how much of this is the result of defects in the law, and what part is the result of poor practice?

Our special concern this morning is title III of the Older Americans Act and its role in meeting these new challenges. Title III has, as its purpose, the development and coordination of services that promote independence and provide a continuum of care for the vulnerable elderly.

Given that the appropriations for title III services have remained basically static for the last 5 years, we need to look at the increased demand being placed on title III agencies and how best they can be dealt with. We have to also look at the priorities of spending in this country, as I pointed out, the appropriations for title III for the last 5 years have been generally static. In that same period of time, the appropriations for the Pentagon have about doubled.

I think we have to ask ourselves, and our witnesses are encouraged to ask, whether this is the right value system, whether indeed we do have our priorities correct in this country. You may suspect my feelings on that subject.

The University of Texas has just completed a study on the new demands being placed on local title III area agencies by those discharged hospital patients who can be indeed extremely vulnerable.

As I have said many, many times—and some of you have heard me say this—this subcommittee has as its care the most vulnerable people in our society—the young, the old, and the poor. When one is both old and sick, there is an ever greater vulnerability that Government should be concerned about.

Our lead-off witness will describe the results of the University of Texas study. We will hear also from several local agency representatives who can give us some insight into what is happening at the local level.

Finally, we will be hearing from the largest of the aging consumer groups, the American Association of Retired Persons, who have a sterling reputation here on Capitol Hill. In a real sense, we are all consumers, now or later, and we need to make the system work in a very humane and effective manner.

We have, as a privilege this morning, a very dear friend of mine and a very effective Member of Congress for a statement, Congressman Mario Biaggi from New York.

Congressman Biaggi.

Mr. BIAGGI. Thank you, Mr. Chairman.

I want to first commend you for holding this hearing on the impact of DRG's on demand for services under the Older Americans Act. It's an issue that's both timely and important as Congress examines how to respond to the growing and ever changing long-term care needs of our Nation's elderly.

We know that under the DRG system patients are being discharged sicker and quicker. According to the inspector general of the Department of Health and Human Services, Richard Kusserow, at least 3,700 Medicare patients were prematurely discharged from hospitals or sent to facilities that provide less care between July, 1984, and March, 1985.

This means that our community systems are being asked, in many cases, to provide services that they are unprepared to do. It means that programs such as the Older Americans Act, which has as its mandate to promote the independence of seniors in communities, are being asked to serve increased numbers of clients without added resources.

In anticipation of this problem, I offered an amendment to last year's appropriations measure which increased funding for title III(b) of the act by $10 million and home-delivered meals by $5 million.

This act was based upon data that we had collected through the Select Committee on Aging which pointed to a number of States, small and large, being faced with a surge of demand for services as a result of premature discharges.

Today's hearing will continue to ask the kinds of questions that I believe will be needed if we are to assure that the Older Americans

Act will be able to respond fully and forcefully to the needs of seniors in the communities.

More importantly, Mr. Chairman, the Older Americans Act, which is the largest Social Service Program for the elderly, needs to play an integral role in the development of a comprehensive, long-term care policy in this Nation.

Today, 11 percent of our total population is over the age of 65. In 50 years, this figure will nearly double. Even more dramatic is the growth in the percentage of elderly over the age of 85 that make up our population. In 1900, it was 4 percent and has grown to 8 percent today and will make up 12 percent by the year 2000.

As a result of this demographic pressure as well as others, your efforts today will begin to ask the kinds of questions where answers are needed.

Once again, I commend you for your effort and want to note that the Select Committee on Aging is anxious to work with this committee on this most important matter.

Thank you, Mr. Chairman.

Mr. KILDEE. Thank you very much, Congressman Biaggi.

Our first witness this morning is Dr. Laura Wilson, director of the Southwest Long Term Care Gerontology Center, University of Texas, Dallas, TX.

**STATEMENT OF LAURA WILSON, DIRECTOR, SOUTHWEST LONG TERM CARE GERONTOLOGY CENTER, UNIVERSITY OF TEXAS, DALLAS, TX, ACCOMPANIED BY, NANCY GORSHE, ASSISTANT DIRECTOR, NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING**

Ms. WILSON. I'd like to thank you for the opportunity to make this presentation this morning. Obviously, because of time, I will only be able to give you the highlights of our national study, and I, therefore, I ask that the complete testimony in its written format be submitted to the record.

Mr. KILDEE. Without objection, it will be included in totality.

Ms. WILSON. Thank you.

This study reports the findings of a national survey which the Southwest Long Term Care Gerontology Center of the University of Texas Health Science Center at Dallas completed with cooperation from the National Association of Area Agencies on Aging. It was done in order to assess any changes in service demand and service delivery patterns under the DRGs.

The study was conducted from April to June of 1985 by the center and looked at surveying approximately 160 area agencies on aging nationally. They were asked to provide information concerning service units delivered, length of service provision, pre- and post-program and budgeting priorities, and their perceptions of hospital referrals and admissions.

About 74 agencies responded, and after assessing this according to capability to respond, the response rate was 69 percent. This represents an adequate representation of the area agency on aging population of agencies and has an adequate distribution nationally of urban and rural agencies.

The purpose of the study, most importantly, was to provide an empirical base for looking at the question of demand for services under DRG's. We attempted to provide a quantitative approach to this issue by collecting actual statistics pre- and post-DRG on the various service areas that we were looking at. So it is, again, a quantitative approach to this issue.

Because of the limitations in the availability of some of the data and the time limitations of this particular study being done in a three-month period, we were not attempting to look at causal relationships. However, you can conclude from the results of this study issues about magnitude of changes and use that as a preliminary step in terms of other research and other kinds of policy development.

Thirteen service categories were selected for in-depth analysis in terms of the kinds of services that area agencies coordinate. These services were selected as most representative without the implication that all area agencies work in all of these 13 service areas, which included case management, health screening, information referral, personal aid, chore services, housekeeping, and adult day care.

Each agency was asked to determine when DRG's had been implemented in their community and to provide data for the year before DRG's and the year following the implementation of DRG's.

Our findings were most conclusive in the area of service units provided. With almost no exceptions, all area agencies reported that there was an increase in the service unit provision in the post-DRG period.

More importantly simply than the increase was the areas where that increase took place, and that was significant. In the area of case management or service coordination, in the post-DRG period there was a 356 percent increase in service unit delivery. In the area of in-home skilled nursing services, there was a 196 percent increase. There were also significant increases in the area of housekeeping, at 69 percent, and personal care of service units, at 63 percent.

We also asked the area agencies to discuss and provide data related to length of time that services were provided and the number of service units per client. For most agencies, both the length of time and the number of units per client was increased, and this trend was even more dramatic the longer an agency was under DRG's.

Some agencies also reported that in order to meet the demand of increasing length of time that services were needed, they had to actually cut the number of service units per client during that length of time. So they were getting fewer service units in order to provide service for a longer period of time.

The agencies were asked to rank their program priorities pre- and post-DRG. In this category, we found significantly little change from the pre- to the post-DRG period, but because budget issues are done on a yearly basis, it would take a longer time for the budget to affect priority issues in the program.

However, 27 percent of our respondents did indicate that where they did make a budget priority change they had to cut services in another area in order to meet the demand of the new priority.

We asked for opinions about whether there were differences in terms of hospital referrals to the area agencies on aging, and they discussed and ranked the various reasons for hospital referrals to area agencies on aging pre- and post-DRG.

There was basic sameness in both periods, but they did indicate an increase in demand for coordination of services, case management, and for personal care services as reasons for referral to area agencies.

Finally, we asked them for their opinion about whether there were changes or reasons for hospital readmission of their clients—of area agency clients—during the post-DRG period that might be different from the pre-DRG period.

In essence, they discussed changes in terms of increased poor physical health, inadequate home services, limited time for discharge planning, and limitations in terms of the family support network.

In summary, we can see that there has been a definite increase in terms of service unit demand and use of community long-term care services in the post-DRG period. Most specifically, this increase in service units is in the areas of service coordination and in-home services, including skilled nursing, chore services, and personal care.

You might conclude, based on these findings, that some of that increase is due, over a period of time, to the increase in the numbers of elderly or to the increase in the old, old population or even because of better press relations, et cetera, in terms of availability of people understanding what the services are.

But because of the vast increase—356 percent, 196 percent, et cetera—in some of these service units and the demands for those kinds of services, you have to look for an environmental factor that was occurring in those communities at that time, and DRG's are one of those factors that you have to look at as a result.

At minimum, these results indicate that the mix of services and the kinds of services that clients are needing during this time period have changed and that that change is significant in terms of need for in-home services and case management for more complicated service needs.

That indicates a more impaired clientele either temporarily or permanently in terms of health impairment, and, because of that, we need to begin to consider whether there has to be a change in terms of funding patterns and priority patterns under the Older Americans Act for these agencies in order to meet these significant changes in demand.

Thank you.

[The prepared statement of Laura B. Wilson follows:]

PREPARED STATEMENT OF LAURA B. WILSON, PH.D., DIRECTOR, SOUTHWEST LONG TERM CARE GERONTOLOGY CENTER OF THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT DALLAS

ABSTRACT

This study reports the findings of a national survey of Area Agencies on Aging concerning changes in service demand and service delivery patterns under DRGs. The study was conducted by the Southwest Long Term Care Gerontology Center (SWLTCGC) in cooperation with the National Association of Area Agencies on

Aging (NAAAA). It is one of the first studies to quantitatively document the kinds and magnitude of changes experienced by the community-based long term care system under DRGs.

The major findings of the study are as follows:

A major shift in service delviery patterns can be identified under the DRG implementation process. Case management service units increased 365% and in-home skilled nursing increased 196%. Housekkeeping and personal care units also averaged substantial increased of 69.2% and 63% respectively.

For most agencies, both length of service and number of units per clinet have increased, and this trend is more dramatic among those agencies where DRGs have been in effect for a longer period of time. Some agencies have been forced to cut number of service untis per client in order to provide servcies for a longer period of time.

Program priorities show little change as yet. Since many of these priorities are determined by Congressional budget allocations, this area may be slow to respond to the changing demand patterns.

Although hospitals continue to make referrals through AAAs for many of the same reasons during pre- and post-DRG periods, greater demands for coordination of services and personal care services was identified after DRG implemention.

Inadequate family support is seen by AAA directors as a major reason for readmission to hospitals. It is this one service area, however, for which a decrease in service untis was documented.

## DRGS AND THE LONG TERM CARE SYSTEM

### *1.0 Introduction*

The financing and delivery of health care in the United States is a complex system involving both individuals and institutions. The societal expense of health care is a function of the contributions of each of these components through preventive health practices as well as acute health care delivery. Despite the involvement of various elements, the components of this system seen as most responsible for costs are hospitals and physicians. As a result, proposal for containing costs generally focus on these factors. However, a closer examination of health care would illustrate the substantial costs incurred by individuals themselves, their friends and family, and the extensive long term care community composed of home health services, nursing homes, nutritional services and a wide variety of other supportive services in the production of health care.

Every presidential administration since Lyndon Johnson's has attempted to deal with the ethical concept of a right to health care within existing economic and political realities. As the federal government's share of the total health care systems' expense has escalated, the search for cost containment strategies has intensified. The latest effort at providing quality care and controlling costs is the Reagan administration's Diagnostically Related Groups (DRGs). DRGs are a form of a flat fee payment to hospitals based on the diagnosis of the patient.

Initially, the cost-containment innovation of DRGs drew little attention from the media. Although this innovation represents major policy implications for health care for elders, the legislation that sanctioned it was easily passed by Congress with little investigation or debate. It was attached to a major legislative proposal to guarantee the solvency of the Social Security System. Although the DRG prepayment system has many supporters, it does represent a major restructuring of the Federal Medicare system. Detractors from the system argue that the reorganization represents an ambitious attempt to contain costs without understanding its impact on the entire health care delivery or the accessibility of health care (Steinberg, 1984).

This study represents an attempt to measure in quantitative terms some of the changes which have occurred in the service delivery patterns and priorities in the long term care system since the implementation of DRGs. A national survey of Area Agencies on Aging (AAA) was conducted to determine any changes in service units delivered, program priority shifts, and changes in demand for varius kinds of activities. To present the findings from this study, the remainder of this report is organized into five sections. Following this introduction, section 2.0 briefly relates the history of the DRG cost containment policy. Section 3.0 summarizes the nature of the sample, the services studied and the organization of the data. Section 4.0 reports the findings of the study, and Section 5.0 presents the conclusions.

### *2.0 DRGS as cost containment policy*

Little argument exists among public officials or consumers that containing health costs represents a significant problem and a major challenge for health policy devel-

opment. Phillip G. Clark (1985) succinctly outlined these concerns in a recent discussion in *The Gerontologist*. Addressing the health care cost issue as a potential source of competition between elders and younger citizens for scarce resources, Clark presents the economic basis of this concern. Hospital care services are the largest health care expenditure category in the United States. At the beginning of the decade, per capita expenditures for the under 65 population were $308, compared to $1,087 for those over 65. The hospitalization rate for the over 65 population is two and one-half times that of the under 65 group. Total national health care expenditures rose from $26.9 billion in 1960 to $224.6 billion in 1980 prior to the introduction of the DRG reform in 1983. More than 10% of the Gross National Product goes for health care expenditures with future projections pointing upward both in real dollar terms and in percent of GNP (DiNitto and Dye, 1983).

With the introduction of DRGs the government reimburses hospitals for the specific diagnoses given to Medicare patients. In the past, the government support was based on length of stay, number of tests, type of care and related factors. Prior to DRGs, payment was cost-based; the DRG system provides a flat-fee payment (Steinberg, 1984). There are 467 DRGs grouped into 23 "major diagnostic categories" or MDCs according to the nature of the disease. A monetary value has been assigned to each diagnostic category. Once the diagnosis has been determined, the payment is also determined regardless of the length of time the Medicare patient stays in the hospital.

To many supporters, this shift seems reasonable since hospitals can no longer boost charges arbitrarily for Medicare services and pass the higher fees on the government. Early observers report that the payment system has altered the way hospitals do business, making them more efficient and cost-conscious, "apparently without damaging the quality of health care," (Pear, 1984). Hospitals make money if they keep costs below the Medicare payment rate, and they lose money if their costs exceed the rate. Pear (1984) quotes H. Bart Price, Vice President of Yale-New Haven Hospital as saying, "The new Medicare payment system has had no adverse effect on the quality of care because the payment rates have been reasonable." These early assessments of the impact of DRGs have unfortunately lacked an empirical basis which took into account a consumer perspective or which recognized the contribution of the long term care system as a component of the health care delivery system. This lack of an empirical base prevents an accurate analysis of a very critical policy question: Do DRGs represent a cost containment policy or do they actually represent a cost shift to individuals or to the long term care system?

Policy analysts have suggested that DRGs may have an unfortunate side effect, giving hospitals an incentive to cut corners on health care. Pro-DRG media coverage report quotations from individuals denying any impact on quality of care. Medicare patients admitted to hospitals under the new payment system have spent an average of 7.5 days in the hospital when in the previous year, pre-DRG, Medicare average stays were 9.5 days. The American Hospital Association reports a similar trend with length of hospital stays declining more rapidly for elderly patients than for patients under 65 (Pear, 1984). The Wall Street Journal reports that Medicare admissions have leveled off (1984). These favorable reports provide no insight into post-hospitalization experiences. No data exist to measure the impact of shortened hospital stays or decreased rates of admission on the long term care system. Because of their substantially greater ourden of chronic disease and disability, the elderly have higher levels of medical need and represent a greater claim on health care services. With their increasing presence in the population, a leveling of admissions in this age group suggests that some health care needs may not be met and that greater attention should be directed to quality, quantity, and access issues.

Most of the analytical attention concerning DRGs has focused on the fixed payment system to such a degree that hospitals can no longer be indifferent to the resources expended in the care of patients. The DRG system mandates a reduction in hospital input per patient. This translates into shortening the average length of stay, reduction of tests, special procedures, supplies and equipment used (Relman, 1985). System responses can also mean reducing number of nurses, orderlies, laundry employees and other support staff.

As hospitals survey the prices Medicare pays for each types of illness, some illnesses will be seen as profitable and others as not, potentially resulting in discriminatory admission policies and a dual system of health care. Critics have argued that the government has as yet developed no accurate method to monitor the quality of care under the new system. Early attention has been directed toward monitoring for fictional diagnoses which fall into a more lucrative categories ("DRG creep") (Steinberg, 1984). Since no empirical evaluation was instituted with the legislation, this far reaching policy has been introduced with no design for systematic, longitudinal

evaluation which goes beyond the changes which can be identified in the hospital milieu.

Early evaluative reports have focused on secondary data which can be tracked from hospital records or secondary data sources. This study represents a first attempt to document the changes in long term care service since the implementation of DRGs.

The true impact of this innovation can never be understood solely by examining changes in length of hospital stay and the supposed resulting cost savings or discriminatory treatment. In fact, these variables may be of little policy interest when compared to a potential shift in the responsibility of the provision of health care. The remainder of this report focuses on AAAs as a critical component of the health care delivery system for elders.

*3.0 Sample, questionnaire format and data organization*

In April, 1985, the Southwest Long Term Care Gerontology Center (SWLTCGC) conduted a random survey of Area Agencies on Aging (AAA) in cooperation with the National Association of Area Agencies on Aging (NAAAA). Approximately 160 agencies were contacted and asked to provide information concerning service units delivered, length of service provision, pre- and post-DRG program and budgeting priorities and their perceptions of the readmission experiences of their client populations. In many cases, the agencies were not yet computerized or had not been computerized for the number of years data were requested. Eleven additional agencies provided anecdotal information concerning their services. While this return represents a 56% response rate overall, a more accurate description would place the response rate at 69% after eliminating agencies who did not have the capability to respond. The responding agencies do represent a wide geographic distribution from both urban and rural areas and can be considered a representative sample of organizations.

A preliminary overview of responses from the first 40 agencies was presented in Senate hearings July 8, 1985. This report represents the final analysis for the 1985 phase of this project.

With the assistance of NAAAA senior staff, thirteen service categories were selected for in-depth analysis. These thirteen represent the kinds of service most likely to be coordinated by local AAAs. However, the list was not intended to be exhaustive nor was any expectation expressed that all agencies typically offered each of the thirteen services. The services selected for study were (1) case management; (2) health screening; (3) information and referral/outreach; (4) in-home skilled nursing care; (5) home delivered meals; (6) personal care or aid; (7) chore services; (8) housekeeping services; (9) adult day care; (10) transportation; (11) congregate meals; (12) family support services; and (13) respite care.

Each agency was asked when DRGs were implemented in their community. Then data concerning service provision were compared for the year prior to implementation and the year following inplementation.

*4.0 Findings*

4.1 Provision of Service Units.—One of the first variables selected to illustrate changes which might reflect an impact of DRGs on service delivery was the number of service units provided in the year prior to and since implementation. With few exceptions, most agencies reported increased service unit provision in the post-DRG time period. The pattern of changes, however, is perhaps the most important point for consideration. Table 1 reports the percent change in service units from the pre-to-post-DRG period. Service unit provision for case management increased 365%, and in-home skilled nursing increased 196%. Substantial increases were also noted for housekeeping, 69.2% and personal care, 63.0%. The service areas which already held a high priority in the pre-DRG period such as nutrition programs and transportation saw much smaller increases. This finding should not be interpreted to mean that these service decreased in importance. Since they already were high priority services, outputs may have been high in the pre-DRG period resulting in a smaller percent change from one period to the next. What can be assumed from the substantial changes noted in the first four categories is that the mix of needs experienced by the clients in different agencies may be undergoing some significant changes. The substantial increases in in-home skilled nursing, housekeeping and personal care indicate a clientele which may be experiencing increasing levels of temporary or permanent health impariments. And the increased emphasis on case management indicates as expanding role for AAA's in the management and coordination of the appropriate service mix.

TABLE 1.—*Percent changes in service unit provision after DRG implementation in individual agencies*

| | *Percent* |
|---|---|
| Case management | +365.0 |
| In-home skilled nursing | +196.0 |
| Housekeeping | +69.2 |
| Personal care | +63.0 |
| Health screening | +16.0 |
| Adult day care | +14.2 |
| Respite care | +12.2 |
| Home delivered meals | +11.3 |
| Chores | +11.0 |
| Transportation [1] | +5.0 |
| Congregate meals [1] | +5.0 |
| Family support | −1.0 |

[1] Tie.

4.2 Length of Time Services Received and Average Number of Units Per Client.—In addition to the total service units provided, attention was also directed to the pattern of service provision, specifically length of time client was served and number of units per client. AAA Agencies were combined into three groups: (1) DRGs implemented in 1983; (2) DRGs implemented in 1984, and (3) Agencies in waiver states or states where DRGs have not yet been implemented. Table 2 summarizes the changes in delivery patterns for the three groups for the pre-and post-DRG periods.

TABLE 2.—COMPARISON OF DELIVERY PATTERNS BY YEAR OF IMPLEMENTATION

[in percent]

| | 1983 implementation | | | 1984 implementation | | | Waivered/not implemented | | |
|---|---|---|---|---|---|---|---|---|---|
| | Same | Increased | Decreased | Same | Increased | Decreased | Same | Increased | Decreased |
| Case management: | | | | | | | | | |
| Length of service | 50.0 | 50.0 | 0 | 60.0 | 20.0 | 20.0 | 66.6 | 33.3 | 0 |
| Service units/client | 33.3 | 66.6 | 0 | 37.5 | 37.5 | 25.0 | 33.3 | 33.3 | 33.3 |
| Health screening: | | | | | | | | | |
| Length of service | 66.6 | 33.3 | 0 | 100.0 | 0 | 0 | 100.0 | 0 | 0 |
| Service units/client | 33.3 | 33.3 | 33.3 | 66.6 | 16.7 | 16.7 | 100.0 | 0 | 0 |
| Information and referral: | | | | | | | | | |
| Length of service | 66.6 | 33.3 | 0 | 85.7 | 0 | 14.3 | 50.0 | 50.0 | 0 |
| Service units/client | 50.0 | 50.0 | 0 | 52.9 | 29.4 | 17.6 | 50.0 | 50.0 | 0 |
| In-home skilled nursing: | | | | | | | | | |
| Length of service | (1) | (1) | (1) | 33.3 | 50.0 | 16.7 | (1) | (1) | (1) |
| Service units/client | 100.0 | 0 | 0 | 11.1 | 55.6 | 33.3 | 0 | 100.0 | 0 |
| Home delivered meals: | | | | | | | | | |
| Length of service | 40.0 | 20.0 | 40.0 | 69.3 | 15.4 | 15.4 | 50.0 | 50.0 | 0 |
| Service units/client | 25.0 | 50.0 | 25.0 | 29.2 | 54.2 | 16.7 | 33.3 | 33.3 | 33.3 |
| Personal care: | | | | | | | | | |
| Length of service | 50.0 | 50.0 | 0 | 40.0 | 30.0 | 30.0 | 100.0 | 0 | 0 |
| Service units/client | 33.3 | 50.0 | 16.7 | 5.6 | 50.0 | 38.9 | 0 | 0 | 100.0 |
| Chore services: | | | | | | | | | |
| Length of service | 66.6 | 33.3 | 0 | 66.6 | 33.3 | 0 | 50.0 | 50.0 | 0 |
| Service units/client | 20.0 | 60.0 | 20.0 | 25.0 | 30.0 | 45.0 | 50.0 | 50.0 | 0 |
| Housekeeping: | | | | | | | | | |
| Length of service | 50.0 | 25.0 | 25.0 | 55.6 | 22.2 | 22.2 | (1) | (1) | (1) |
| Service units/client | 0 | 60.0 | 40.0 | 31.2 | 18.8 | 50.0 | (1) | (1) | (1) |
| Adult day care: | | | | | | | | | |
| Length of service | 33.3 | 66.6 | 0 | 28.6 | 42.9 | 28.6 | 100.0 | 0 | 0 |
| Service units/client | 0 | 80.0 | 20.0 | 0 | 70.0 | 30.0 | 100.0 | 0 | 0 |
| Transportation: | | | | | | | | | |
| Length of service | 75.0 | 25.0 | 0 | 80.0 | 20.0 | 0 | 100.0 | 0 | 0 |
| Service units/client | 14.3 | 71.4 | 14.3 | 18.2 | 50.0 | 31.8 | 50.0 | 50.0 | 0 |
| Congregate meals: | | | | | | | | | |
| Length of service | 60.0 | 20.0 | 20.0 | 58.3 | 25.0 | 16.7 | 100.0 | 0 | 0 |
| Service units/client | 16.7 | 16.7 | 66.6 | 45.5 | 36.4 | 18.2 | 50.0 | 0 | 0 |

TABLE 2.—COMPARISON OF DELIVERY PATTERNS BY YEAR OF IMPLEMENTATION—Continued

[In percent]

| | 1983 implementation | | | 1984 implementation | | | Waivered/not implemented | | |
|---|---|---|---|---|---|---|---|---|---|
| | Same | Increased | Decreased | Same | Increased | Decreased | Same | Increased | Decreased |
| Family support: | | | | | | | | | |
| Length of service | 0 | 100.0 | 0 | 100.0 | 0 | 0 | (1) | (1) | (1) |
| Service units/client | 0 | 100.0 | 0 | 12.5 | 75.0 | 12.5 | 100.0 | 0 | 0 |
| Respite care: | | | | | | | | | |
| Length of service | 0 | 100.0 | 0 | 0 | 66.7 | 33.3 | 100.0 | 0 | 0 |
| Service units/client | 0 | 66.6 | 33.3 | 20.0 | 60.0 | 20.0 | 50.0 | 50.0 | 0 |

[1] Information not available.

For many agencies, data concerning average length of service delivery per client were not kept. Those agencies where DRGs had been in effect longer tended to show more increases both in length of service and number of units per client. In a few instances, agencies were coping with increasing and continuing demands by increasing length of service but decreasing the number of units per clients. Among the agencies where DRGs had been in effect longer, the services where this strategy had been used were health screening, personal care services, chore services, adult day care, transportation, congregate meals and respite care.

Among the agencies where DRGs were implemented in 1984, similar patterns were observed. The number of agencies increasing length and service units were not as substantial, but the same patterns of increasing length of services while providing fewer units per person was observed. In addition to those identified for the 1983 group, 33.3% of the 1984 group had to decrease the number of service units per client receiving in-home skilled nursing care. The waivered states or non-DRG agencies more often reported that their delivery patterns remained the same during comparable time periods.

4.3 Program Priorities.—One important question which any study attempting to understanding the impact of DRGs on the long term care system must ask concerns the impact of this cost containment policy on the priorities of the system itself. Ideally, program priorities have been determined by local decision makers to reflect the identified needs in specific areas. A federally mandated cost-containment policy can have the effect of forcing a system to respond or react to a crisis situation, changing its direction and emphasis as a result of external forces rather than internally directed responses to expressed needs. Congressional financing may indeed determine priorities.

All agencies were asked to rank the top six program priorities defined in terms of percent of budget expenditures for the pre- and post-DRG period. Table 3 summarizes the results. In the two time periods, the first five service priorities remained the same. Nutrition programs remained a top priority in both periods with home delivered meals and congregate meals ranking first and third. The ranking may reflect the amount of funding that Congress allocates for nutritional programs. Transportation ranked second in both periods, and personal care and case management remained in fourth and fifth places. Information and referral dropped from sixth to seventh position. Legal aid increased one position in post-DRG priorities and housing assistance decreased one position.

TABLE 3.—*Program priorities in pre- and post-DRG implementation periods*

| *Pre-DRG* | *Post-DRG* |
|---|---|
| Home delivered meals | Home delivered meals. |
| Transportation | Transportation. |
| Congregate meals | Congregate meals. |
| Personal care | Personal care. |
| Case management | Case management. |
| Information and referral [1] | Chore service. |
| Chore service [1] | Housekeeping.[1] |
| Housekeeping.[2] | Information and referral.[1] |
| Senior centers/counseling [2] | Senior centers counseling.[1] |
| In-home nursing services | In-home nursing services. |
| Adult day care | Adult day care. |

TABLE 3.—*Program priorities in pre- and post-DRG implementation periods—Continued*

| *Pre-DRG* | *Post-DRG* |
|---|---|
| Housing assistance | Legal aid. |
| Legal aid | Housing assistance. |
| Family support [3] | Health screening. |
| Health screening [3] | Family support. |
| Respite care | Respite care. |

[1] Tie for 6th.
[2] Tie for 7th.
[3] Tie for 12th.

Since budget changes are made only on a yearly basis, changes in priorities may take a great deal of time to filter into the system. Only a longitudinal study which traces changes over a longer period of time may be able to identify systemic changes.

More than one quarter of the agencies, 27.3%, reported they had to cut services in one or more areas in order to support any changes in priorities. Although transporation was identified as a high priority, cuts were more likely to be made in this area than in any other. The rationale for cutting in this area may be the large expense that is involved in the provision of this service.

4.4 Hospital Referrals to Agencies.—To determine if the reasons hospitals refer their patients to agencies might changes after implementation, respondents were queried concering hospital referrals. Table 4 summarizes these responses. The ranking of the first three reasons (home delivered meals, home care, and transportation) remained the same during the pre- and post-DRG time periods. Consolidated access/outreach and Medicaid personal care were mentioned more often as reason for referral during the post-DRG period. Congregate meals decreased in importance for referrals after the implementation period. Emergency services increased in importance during the post-DRG time frame.

TABLE 4.—*Reason for hospital referrals to agencies ranked by demand*

| *Pre-DRG implementation* | *Post-DRG implementation* |
|---|---|
| Home delivered meals | Home delivered meals. |
| Home care | Home care. |
| Transportation | Transporation. |
| Congregate meals | Consolidated access/outreach. |
| Consolidated access/outreach | Medicaid personal care. |
| Respite care [1] | Congregate meals.[1] |
| Medicaid Personal Care [1] | Respite care.[1] |
| Adult day care | Adult day care.[2] |
| Emergency services | Emergency services.[2] |
| Service to persons in institutions | Service to persons in institutions. |
| Health screening | Health screening. |

[1] Tied for 6th.
[2] Tied for 7th.

4.5 Hospital Readmissions.—The final two questions presented to the AAAs concerned their impressions of what problems contributed to the readmission of their clients during the post-DRG period and what could have been done to prevent or delay the readmissions. The survey instrument presented several options and respondents could agree with or eliminate as many responses as they wished. Table 5 summarizes the perceptions concerning which problems contribute to hospital readmissions. Almost three-fifths of the respondents believed overall impaired physical status to be a major contributing factor. Inadequate family support was mentioned by almost 50%, and inadequate home support services such as meals on wheels was mentioned by 44.3%. Inadequate time for discharge planning was named by 39.2%. Mental impairment was mentioned by 22.8%, unavailable home health service by 21.5%, and insufficient number of skilled care beds by 17.7%.

TABLE 5.—*Perception of problems contributing to hospital readmission since implementation of DRG policy*

| | Percent |
|---|---|
| Overall impaired physical status | 57.0 |
| Inadequate family support | 49.4 |
| Inadequate home support service | 44.3 |
| Inadequate time for discharge planning | 39.2 |
| Overall impaired mental status | 22.8 |
| Unavailable home health services | 21.5 |
| Insufficient number of skilled care beds | 17.7 |

Table 6 reports the perceptions of what could have been done to avoid or delay readmission. Family support was named by slightly more than half, 50.6%, of the respondents. This perception is particularly interesting in view of the findings that family support service was the only one for which a decrease in service units was indicated. Availability of additional community resources was mentioned by almost half, 49.4%. Longer hospitalization was named by 43% and more time for discharge planning by 40.5%. Patient compliance and availability of skilled nursing beds were mentioned by 19% and 16.5% respectively.

TABLE 6.—*Perceptions of what could have prevented or delayed readmissions*

| | Percent |
|---|---|
| Family support | 50.6 |
| Availability of additional community resources | 49.4 |
| Longer hospitalization | 43.0 |
| More time for discharge planning | 40.5 |
| Patient compliance | 19.0 |
| Availability of skilled nursing beds | 16.5 |

*5.0 Summary and conclusions*

This study represents one of the first attempts to empirically document the changes in service demand and delivery patterns experienced by the community-based long term care system under the DRG policy implementation. It represents a focus on a separate but critical component of the health care delivery system for elders. Adding concern for this system component to the already documented changes experienced by hospitals provides a broader based and more accurate picture of the impact of the DRG policy. This study was not designed to identify causal relationships. One can, however, point to the magnitude of changes that have occurred in some service areas. While changing demographics and effective public relations campaigns may account for some of the increases in service demands, it would be foolhardy to attempt to explain such major shifts with these variables. Major changes have occurred in the long term care system and some of the responsibility for those changes could be attributed to DRGs. To summarize the major findings of this study, the following points are reiterated.

A major shift in service delivery patterns can be identified under the DRG implementation process. Case management service units delivered increased 365 percent, and in-home skilled nursing increased 196 percent. Housekeeping and personal care units also averaged substantial increases of 69.2 percent and 63 percent respectively.

For most agencies, both length of service delivery and number of units per client have increased, and this trend is more dramatic among those agencies where DRGs have been in effect for a long period of time. Some agencies have been forced to cut number of service units per client in order to provide services for a longer period of time.

Program priorities show little changes as yet. Since many of these priorities are determined by Congressional budget allocations, this area may be slow to respond to the changing demand patterns.

Although hospitals continued to make referrals through AAAs for many of the same reasons during pre- and post-DRG periods, greater demands for coordination of services and personal care services were identified after DRG implementation.

Inadequate family support is seen by AAA directors as a major reason for readmission to hospitals. It is this one service area, however, for which a decrease in service units was documented.

These findings require some re-thinking of the service delivery structure and funding priorities in the long term care system. The image of the long term care system as serving primarily frail elderly in institutional settings is too limited in scope. The cost containment policy appears to be shifting a major portion of the

burden of health care to the community-based care system. More and more individuals who may be temporarily impaired post-hospitalization are requiring a different mix of services to return to a functional status and avoid further costs for institutionalization. These community services are critical to the long term care systems and must be recognized in policy and in funding priorities to enable the long term care system to respond to elder needs.

While thorough understanding of the impact of DRGs awaits more sophisticated longitudinal research on hospitalized individuals themselves, these early assessments of organizational impact demand consideration of policy modifications. Cost containment is of legitimate concern to the American public. But this concern must be balanced with quality of care and access issues to assure all elders in the United States of a basic level of health care.

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# Southwest Long Term Care Gerontology Center

## Operational Centers

**Pacific Northwest Long Term Care Center**
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Seattle, Washington 98195
206/543-8727

**Long Term Care Gerontology Center**
University of Utah – College of Nursing
University Medical Center
50 North Medical Drive
Salt Lake City, Utah 84132
801/581-8198

**Milwaukee Long Term Care Gerontology Center**
Medical College of Wisconsin
The Milwaukee County General Hospital
8700 West Wisconsin Avenue
Milwaukee, Wisconsin 53226
414/257-6477

**Southeastern New England Long Term Care Gerontology Center**
Division of Biology and Medicine
Brown University, Box G
Providence, Rhode Island 02912
401/863-3489

**UCLA/USC Long Term Care Gerontology Center**
School of Medicine (CHS)
10833 LeConte Avenue
Los Angeles, California 90024
213/825-8255

**University of Arizona Long Term Care Gerontology Center**
1317 E. Speedway
Tucson, Arizona 85719
602/626-4854

**Southwest Long Term Care Gerontology Center**
University of Texas Health Science Center at Dallas
Gerontology Services Administration
3323 Harry Hines Boulevard
Dallas, Texas 75235
214/350-5011

**Long Term Care Gerontology Center**
University of Kansas College of Health Sciences and Hospital
39th and Rainbow Boulevard
Kansas City, Kansas 66103
913/588-1203

**Suncoast Gerontology Center for Health and Long Term Care**
USF College of Medicine
12901 North 30th Street, Box 50
Tampa, Florida 33612
813/974-4355

**Center for Geriatrics and Gerontology/Long Term Care**
Faculty of Medicine
Columbia University
100 Haven Avenue, Tower 3-29F
New York, New York 10032
212/781-0600

**Mid-Atlantic Long Term Care Gerontology Center**
Temple University – Room 207
1601 North Broad Street
Philadelphia, Pennsylvania 19122
215/787-6970

# Southwest Long Term Care Center

The Southwest Long Term Care Gerontology Center started with a planning grant Oct. 1, 1982, and began full operation with continued funding from the Department of Health and Human Services Administration on Aging on October 1, 1983.

As one of eleven national Long Term Care Gerontology Centers the Southwest Long Term Care Center is located at the University of Texas Health Science Center at Dallas, (UTHSCD).

The concept of long term care envelops the variety of medical, mental and social service needs of elderly ranging from relatively minor disabilities such as walking up stairs or reading a prescription bottle, to mental dysfunction and incapacitation.

The scope of the national problem of finding answers to the current and future needs of long term care for the growing number of elderly includes such considerations as demographics, the costs of long term care to the nation, and human considerations.

- With the proportion of the elderly over 85 growing rapidly, the ranks of those who are vulnerable to disease and physical or mental deterioration are increasing.
- The cost of long term care to both the individual and the public is rising. More than $42 billion was spent by Medicare in 1981 for nursing home care. Billions more were spent for other forms of long term care.
- Fragmentation of services in providing long term care has been a major problem, often resulting in the use of costly institutionalization as a last resort.

The Administration on Aging has charged the Long Term Care Gerontology Centers with the task of coordinating long term care efforts, and developing creative and cost-effective solutions to this national problem.

Like the other 10 centers, the Southwest Long Term Care Gerontology Center is based within an academic health science center setting. The Center is a multi-disciplinary approach among academicians, the medical community, and community-based health and social service providers.

**Center Operating Concept**

The Center is a cooperative effort among these academic communities:

- University of Texas Health Science Center at Dallas (School of Allied Health Sciences and Southwestern Medical School).
- University of Texas at Arlington (School of Nursing and Institute for Urban Studies).
- University of Texas at Austin (School of Social Work).

Each school participates in multi-disciplinary training in geriatrics or gerontology, develops research, and participates in model sites which are a focus of research, educational and service activities.

The Southwest Long Term Care Gerontology Center serves as an information resource, training aid, and research partner to the community-based service agencies, and federal, state and local agencies on aging located in the Department of Health and Human Services Region VI which includes:

Arkansas,
Louisiana,
New Mexico,
Oklahoma,
Texas.

1413
1463
260
287

# Interdisciplinary Education And Training

The goal of this division has been the creation of curriculum in gerontology and geriatrics for students in several disciplines, with emphasis on developing the concept of interdisciplinary team training.

Students and practicing professionals in the fields of medicine, nursing, social work and the allied health professions will benefit from this cross-disciplinary training designed to improve the knowledge and skills of current and future long-term care providers.

### Interdisciplinary Training

A goal of the Southwest Long Term Care Gerontology Center is to expand interdisciplinary gerontology training among a variety of health care curricula at nearby universities. The Center is working with departments at UT Southwestern Medical School, the School of Allied Health Sciences, UTA School of Nursing and UT School of Social Work to determine where the Center's courses might play a role in their respective curricula and to expand geriatrics/gerontology curriculum in those settings.

### Training Manual

The Center staff is writing an original manuscript for a training manual on interdisciplinary team approaches to long term health care of the aged. When published, the book will fulfill a need for a resource combining theory and practice with creative training materials for use by interdisciplinary teams in long term care settings.

### Medical School Training

Geriatric training within medical school curriculum is being expanded with planning assistance from the Long Term Care Gerontology Center. Through cooperation with departmental chairs of surgery, psychiatry, geriatrics, physical medicine, and general medicine, educational plans are being developed.

### Gerontological Counseling

The staff is developing a master's level degree program in gerontological counseling. Expanding upon the Center's current graduate education offerings, a complete master's curriculum in gerontological counseling is being developed and submitted to the University of Texas for approval.

Expected to train four to six students per year, the program's aim is:

- To produce counselors whose skills are relevant to the realities of aging,
- Provide a solid foundation in both gerontology and interpersonal helping skills,
- To fill a gap in the gerontological offerings in the University of Texas system.

### Gerontological Social Work Courses

At the University of Texas at Austin, the Center is assisting with the development of special emphasis on gerontological social work within the School of Social Work. Faculty development and social gerontology coursework is being implemented. Course offerings in gerontological social work will be expanded at both Austin and Dallas locations.

Students in this area will be urged to attend national and regional gerontology conferences and educational field work will be developed. Gerontological research in the School of Social Work will be stimulated with an awards program. And a professional in

gerontology will be sought to fill the recently endowed chair in gerontological social work at UT Austin.

**Gerontological Nursing Programs**

Gerontological Nursing at the University of Texas at Arlington will be expanded to become a significant resource in this field. Two new courses in the geriatric nurse practitioner degree program are being developed. Those students will also enroll in gerontology courses at the Southwest Long Term Care Gerontology Center.

Students will gain experience in a variety of arenas including hospitals, nursing homes, community and rural living settings. Research into Alzheimer's Disease and a study of nutrition for nursing home residents are underway, with other research topics being planned.

Continuing education activities include cosponsoring a conference on aging with the UT Austin School of Social Work. The center also is conducting a major regional nursing workshop on aging, and developing a training program for nurses who are pursuing careers in nursing home administration.

**Veterans Administration Medical Center at Dallas**

The Southwest Long Term Care Gerontology Center and the Veterans Administration Medical Center at Dallas have cooperated on the development of team training for long term care professionals in VA hospitals. The Center and the Dallas hospital expect to conduct four regional training sessions yearly and are producing a manual to help replicate this long term care team training activity.

As a result of the liaison between the Center and the VA Medical Center, three Center staff were invited to receive joint appointments at the medical center in the Nursing Home Care and Surgery Units.

**Professionals As Educators**

To promote the expansion of the interdisciplinary team training concept, the Center will help identify professionals in various disciplines in the aging network to become educators in their area of expertise. Additionally, the Center will locate in each state a committee representing several disciplines within the aging network, to promote educational activity with an interdisciplinary approach.

The Southwest Long Term Care Gerontology Center in Dallas, as well as the UT School of Nursing in Arlington, and the UT School of Social Work in Austin will serve as resources.

# Division Of Continuing Education

SOUTHWEST LONG TERM CARE GERONTOLOGY CENTER

The Center's division of continuing education provides the opportunity for working professionals in a variety of fields to improve their knowledge and skills for working with the elderly.

To provide continuing education opportunities in gerontology to the greatest number of professionals in a wide variety of settings, the continuing education division is implementing training programs in several areas. These opportunities are being made available to state affiliated aging network professionals as well as to personnel in the private sector.

**Certification For Professionals**

To promote a level of expertise the Center is currently developing a training system so that participants who complete certain continuing education units may be certified.

At the same time, a core of professionals in the region will be supported by training as needed.

Curricula are being developed to reflect the various needs in the field of aging. Continual evaluation will keep the continuing education offerings relevant.

### *Paraprofessional Training*

Paraprofessionals such as food managers, drivers and caseworkers are important linkages in the service network to the elderly. Cooperating with the Southwest Society on Aging (SWSA), the Center is developing continuing education programs for those paraprofessionals who have frequent contact with elderly clients when providing such services as housekeeping, transportation, and food preparation.

The Center and SWSA are completing a grant application to obtain funding for region-wide paraprofessional training. The goal is to provide four workshops throughout the five-state region, supplemented with video training tapes on key topics including the difficult client, bereavement and nutrition.

### Client Assessment Tools

On a national level, the Southwest Long Term Care Gerontology Center is an active participant with the other long term care centers in seeking funding for a project on case management assessment tools.

The National Association of the Area Agencies on Aging and the National Association of State Units on Aging are assisting in this development work. Columbia University Long Term Care Gerontology Center is preparing the grant and will take the lead role.

### State Training Plans

Each state unit on aging receives the Center's assistance in developing a continuing education plan according to the state's needs. The Center contracts with each state in the region to provide training.

### Training For Associates

The Center is contacting professional associations in health related fields to offer continuing education assistance in gerontology topics to those professionals most likely to work with elderly clients or patients.

### Training For Businesses

The Center also is seeking to assist private sector businesses wanting to be responsive to issues of aging. Many businesses, such as health maintenance organizations, offer programs on aging and health. Other companies offer retirement planning programs.

The Center will provide training to private sector personnel in topics including retirement planning, the older worker, or drug interaction.

### Minority College Programs

To develop curriculum in historically Black colleges in the region, the Center is actively participating in a grant application process in cooperation with North Texas State University. Twenty-one historically Black colleges and other institutions serving minorities are located within the Center's service region.

If funded, the grant would include faculty training and faculty exchanges of scholars among those colleges and active gerontology programs in the region.

### Conferences And Workshops

During the first year of operation the Southwest Long Term Care Gerontology Center participated in several conferences and workshops. Among those were:

- A training conference was cosponsored with the Department of Community Medicine and the Division of Geriatric Medicine titled "Assessing The Elderly: Issues and Answers."

- A two-day conference on Alzheimer's Disease and Related Disorders (ADRD) was cosponsored with the local ADRDA chapter, the National Council of Jewish Women, The Dallas Area Agency on Aging (AAA), Dallas Geriatric Research Institute, Dallas Home for the Jewish Aged.

- A two day workshop on the Family Caregiver was developed with the regional Administration on Aging (AoA) office, American Association of Retired Persons (AARP), The Public Health Service and SWSA. The 300 participants received training on the topic of forming family caregiver support groups in rural areas.

- Inservice education in aging was provided for lay ministers in training at a local hospitals. They help older people and their families before, during and after a hospital stay.

- An educational program was given for grown children of institutionalized parents. The discussion focused on the emotional impact of placing a parent in a nursing home, the feelings of guilt, coping mechanisms, as well as the elderly's reactions to residing in a long term care facility.

- Case management training was provided to the office on aging staffs in New Mexico, Louisiana, and Texas. A health promotions conference was held in Oklahoma City and assistance was given to Arkansas in developing a proposal for training funds.

# Service And Practice Models

Through the use of service and practice models, the Southwest Long Term Care Gerontology Center has combined education, research and service delivery into working models. Two major Dallas area models were put into operation during the first year as well as a program in rural northeast Texas. The Center's efforts are now directed towards replicating these models in the five-state area, as well as developing new models throughout the region.

Emphasis at the model sites is focused on case management, health promotion, discharge planning, hospital/community coordination of care and interdisciplinary geriatric team development.

**Parkland Memorial Hospital Model**

Parkland Memorial Hospital served as a site for the development of a geriatric assessment unit model. Separate funding from the Robert Wood Johnson Foundation supports this project as one of 25 such models across the country in the foundation's Hospital Initiatives in Long Term Care Program.

The funding for this four-year project provides for a geriatric assessment team consisting of:

1. a geriatrician,
2. nurse practitioner,
3. case managers,
4. a gero-psychiatrist and
5. an evaluator/planner.

The mission of this project is to improve the quality of care for frail elderly patients, and to strengthen the procedure by which these elderly enter the long term care system after hospital discharge.

With 300 elderly patients seen in experimental and control groups, a pilot test of all geriatric assessment team procedures analyzed the project.

The Center is formalizing the replication methodologies developed from the Parkland Memorial Hospital experience, to transfer to public hospitals in other parts of the region.

### Veterans Administration Medical Center Site

The second major Dallas area model site is the Veterans Administration Medical Center where a model of interdisciplinary team development is underway. The newly constructed 120 bed VA extended care unit opened in September 1984. The Center has worked with this unit in team development, training, information dissemination, assessment instrumentation and research.

The Center coordinates weekly team development conferences and meetings with the extended care unit; and quarterly training for the team and general hospital personnel on geriatrics and team development issues.

The Center plans to work with regional and national Veterans Administration officials to consider methods of replicating this multi-disciplinary approach to care in the VA long term care units. The Center anticipates working with at least four additional VA medical centers.

### Elderwatch Model

Elderwatch is the name of a rural service model operating cooperatively with the Texoma Area Agency on Aging in Denison, Tx. Funded by the Levi-Strauss Foundation, Elderwatch is an innovative program providing a range of in-home services by trained neighborhood volunteers to rural elderly.

Elderwatch is serving as a model in-home assistance program for serving frail elderly in homes scattered across the countryside. The Center is involved in developing training materials and methods to analyze the program for replication in other rural settings.

The Southwest Long Term Care Gerontology Center is assisting in developing a method to assess the extent of clients' disabilities, providing twice-yearly training for the volunteers who will provide the in-home services, and developing a drug interaction computer program for Elderwatch use. The Center is video-taping the training sessions and writing a training manual to enable the project to be replicated in other rural areas of its service region.

### Wellness Promotion Models

Two wellness promotion models revolved around the development of a computer program to catch the possibility of dangerous drug interaction specific to the elderly. The purpose of this software, combined

with training and research, is to reduce the number of hospital admissions caused by inappropriate mix or dosage of drugs used by elderly.

Drugs prescribed in the appropriate amount for a younger person can be highly toxic for an elderly patient. And because elderly often take so many drugs, care must be taken to avoid toxic combinations.

- With money donated by Atlantic Richfield Corporation (ARCO), software has been developed and will be used this year in the Elderwatch program as well as in a pilot test in cooperation with the AARP Pharmacies in Texas.
- The state of Arkansas plans to use the drug interaction program and expand the concept even further by providing drug registry through their senior centers and training for the elderly and their families in appropriate drug usage.
- Plans call for seeking cooperation with supermarkets and pharmaceutical companies to replicate this drug interaction program nationwide.

**Case Management Replication**

The Center is assisting several regional case management projects to develop packages for replication throughout the region.

- The Access Center for the Elderly (ACE) in Dallas is a successful multi-agency case management project. Developed by the Dallas Area Agency on Aging, the ACE concept has been adopted in Louisiana where the Center has provided technical assistance.

The Texas Project for Elders in Houston, a national channeling demonstration project, also is working with the Center to develop a replication package. The Center is helping to expand its caregiver manual beyond the current Houston focus. And in July, 1984 the Center and the Texas Project for Elders cosponsored a Family as Caregiver Conference with 267 participants.

**Legal Advocacy Replication**

In late 1985 the Center plans to assist the state of New Mexico in documenting the state's legal advocacy program for the aged and to work with other states interested in a similar program.

# Research

Research by the Southwest Long Term Care Gerontology Center into long term care issues is oriented toward the practical and applied use of research findings by the aging network and community service providers. This approach is based on the recognition that the long term care services are offered in community-based formal and informal systems.

The Center is encouraging a research network among the region's universities to promote applied and policy-oriented research on topics related to each state's needs.

Three major goals of the research division include:

(1) the study of the major components of the long term care delivery system and the identification of barriers within that system;

(2) the study of demographic, epidemiologic and economic factors which influence the delivery and use of services;

(3) the study of the impact of single and combined efforts of different services on elderly and disabled persons with different patterns of need.

In accordance with the major goals of the research division, the Center is completing research on these specific topics:

**Effect Of DRGs**

■ Funded by a University Institutional Research grant the study will determine the effects of diagnostic related groups (DRGs) and the Medicare prospective payment system on the length of stay of elderly patients and their subsequent discharge to a community based long term care facility.

Eight DRGs have been examined representing more than 1,000 discharged patients of Parkland Memorial Hospital. The findings are now being analyzed and prepared to report. From these findings the Center will develop a national data base on the impact of the DRGs on community long term care.

**Needs And Uses Of Services**

■ Another research project, funded by the AoA, will help identify the patterns of need and uses of services by the elderly, and to devise means of determining the most effective and efficient match of need and service. The Center will publish a scientific methodology paper, as well as a non-technical manual for use by service providers.

**Use Of Gynecological Services**

■ The Department of Family Practice at UTHSCD requested that the Center conduct a study of the use of gynecological services by older women. The study interviewed 75 women in a congregate housing development to determine the need for specific services in local communities.

**Mortality In Nursing Homes**

■ The National Institute on Aging funded a study on mortality in nursing homes. The study analyzes the institutional factors underlying the risk of mortality in nursing homes. The Center will distribute results through academic journals and to all Area Agencies on Aging in the region.

**Physician Distribution**

■ Another study funded by the University of Texas Board of Regents will quantify the changes in distribution of physicians among the elderly population between the years 1970 and 1980.

**Medical Services For Disabled**

■ The Center has been conducting a study of the relationships between the use of medical services and varying levels of disabilities among those age 55 and older. The project uses recently released National Center for Health Statistics National Medical Care Expenditure Survey of 1977 data. The Center anticipates that this project will form the basis for a proposal of larger research project with yet to be released data from the National Center for Health Statistics.

**Long Term Care Data Book**

■ The Center staff is studying the region's long term care population with the goal of producing a data book detailing the economic, demographic and epidemiologic characteristics of the long term care population in the region's five-state area. The manual will be distributed to the state units on aging and the 96 Area Agencies on Aging.

**Regional Research Network**

■ To promote interest in long term care throughout the region the Center is establishing a regional university long term care research network. Lines of communication are being established with social, behavioral and health related academic departments in at least 20 universities and colleges in the five-state region.

Coordination of efforts is planned through a regional seminar at the annual Southwest Society on Aging meetings, as well as a newsletter targeted to academic researchers in social, behavior and health sciences.

**Data Base Project**

■ The Center is researching the effect of computerized client tracking and case management system on elderly discharges from Parkland Memorial Hospital. As part of the Robert Wood Johnson Foundation Hospital Initiatives in Long Term Care, the Center will evaluate the impact of this project on the well-being of those 300 cases. This study will add to the national data base collected from the 25 other Robert Wood Johnson projects.

**Arkansas Screening Project**

■ At the request of the Arkansas State Office on Aging, the Center is designing and supervising a study of the state's pre-admissions screening project designed to prevent inappropriate institutionalization.

**Texas Long Term Care Needs**

■ The Center will assist the Texas Department of Human Resources in analyzing the data collected biennially on the needs of the elderly long term care population. The Center will supplement this data with information gathered from a survey of 3,000 people to make a report of needs to the Texas Long Term Care Coordinating Council.

# Technical Assistance And Regional Resource

SOUTHWEST LONG TERM CARE GERONTOLOGY CENTER

The Southwest Long Term Care Gerontology Center has defined technical assistance in the field of long term care for its five-state region as a priority. The center provides assistance to governmental agencies, universities and health science centers, professional associations, businesses and state legislatures.

- As a regional resource in technical assistance, the Center works in research, education and service model development within each state and at a regional level. The Center seeks to promote liaisons between agencies within and between states, and to utilize expertise and information from the other long term care gerontology centers to the benefit of this Southwest region.
- Workshops and conferences, demonstration projects, training, development of research projects, and information dissemination mentioned earlier are all part of the Center's mission of serving as a technical assistance and regional resource center.
- The Center staff initiates or participates in meetings which have state or regional perspectives, providing resource information regarding long term care policy issues.

■ The Center acts as a catalyst to bring together researchers and practitioners for the exchange of information on issues in long term care. Many of the Center's planned workshops will provide this exchange opportunity. A regional Directory of Research in Aging relating current research projects will be published for the aging network, universities and colleges in the region.

■ The Center works as a national resource by developing joint projects with other long term care centers and with national aging-related organization.

**Resource For States**

Of key importance is the center's role as a regional resource for the individual needs of each of the five states.

**Arkansas**

■ The Center helped the Arkansas unit analyze its population statistics in terms of future needs of health care financing.

■ A long range plan for a community based long term care system was developed in cooperation with the Center. The Center will assist in the formation of a governor's conference on long term care.

■ The Center is evaluating Arkansas program demonstrations on client assessment teams, personal care and day care.

■ To develop funding for program development, the Center will assist the state office on aging in approaching foundations for grants.

**Louisiana**

■ A needs assessment survey from the 1980 census will help Louisiana pinpoint nutritional and supportive services needs for noninstitutionalized elderly on a parish-by-parish basis. The Center will work with the state unit and local area agencies on aging to determine what types of data they need to make their funding requests to fulfill these needs.

■ Continuing and inservice education on community based long term care is a particular interest in Louisiana. The Center is providing training, targeting funding resources, and defining specific community based alternatives such as housing, home health, adult day care and homemaker services.

■ The Center is providing legislative assistance to the state unit on aging and area agencies. The Center analyzed data and provided background materials for the state agencies to use in preparing their legislative requests.

■ The Center provided information on coordinating community based long term care systems with particular emphasis on costs, staffing, problems and application in rural areas.

■ The state is considering a case management project based on the replication of the ACE project in Dallas. The Center offered training in case management and ACE replication in two workshops in Baton Rouge and developed a step by step approach to replicating ACE.

■ The Governor's office is interested in modifying current adult protective services legislation to more appropriately meet the needs of adults. The Center will provide information on comparative legislation from other states, and make recommendations.

**New Mexico**

- The Center provided the state unit on aging in New Mexico with a statistics and census data analysis to be used in compiling a legislative needs document.
- The Center developed training on case management and long term care for the area agencies on aging staffs throughout the state to help each AAA develop case management with a long term care coordinator.
- Training was planned for dietitians in the area agencies.
- The state requested the Center's participation reviewing the state's mandate on combining public health and primary care with regard to the needs of the elderly.
- The Center helped develop the legal services component which the AAAs are required to offer.

**Oklahoma**

- The Center helped the state unit on aging determine possible sources of funding from Oklahoma-based and national foundations. The Center suggested that projects with an entrepreneurial emphasis may be appealing to funders.
- Nursing home issues and their relationships to the community was a topic the Center dealt with. The Center provided the state officials with recent research papers concerning the impact of DRGs on nursing homes and projected trends in nursing home admissions due to expansion of community alternatives.
- The Center cooperated with Oklahoma to conduct a research project to determine the true costs per service unit and true costs to service an individual in a long term care system. With the results suggestions were made to sites which were not operating cost effectively.
- With a two-day workshop the Center provided assistance with an ACE replication model. The Center also reviewed the geriatric assessment tools currently being used.
- The Center assisted the state and AAAs in preparing a proposal on key issues in long term care for Oklahoma state legislators.
- Training the trainer activity in a wellness promotion was desired by the state. The Center cooperated by coordinating the training workshop with a similar program by the University of Texas.
- With continuing education opportunities, the Center will assist in developing statewide training and career development in long term care professions.

**Texas**

- Case management was the number one priority for all AAAs responding to a questionnaire from the center. The Center will provide information to all AAAs describing best practice models across the United States detailing management, operations, funding, cost per unit and application to Texas. A case management seminar was held in Corpus Christi and other intensive training workshops were scheduled.
- A technical assistance paper on the development of family support groups for use by the AAAs was prepared. The Center cooperated with the Texas Project for Elders in providing a workshop on the replication of their family support training and service model. A conference on family support was planned with the regional Administration on Aging Office and the Southwest Society on Aging.

- Interest was expressed in the development of respite care programs. The Center reviewed other respite care projects and provided a research paper reviewing models of respite care.
- Financial self-sufficiency of community based programs was another topic addressed by Center. The Center surveyed key community based services to determine cost per service and innovative and constructive financing options. The Center plans to conduct a workshop from the survey findings.
- Many of the AAAs have access to a personal computer. The Center was requested to help upgrade and refine the use of these computers. The Center will work with the Kansas Long Term Care Gerontology Center to distribute software developed for AAAs in Texas.
- The Center will assist the Texas Department on Aging with technical support for the Governor's Long Term Care Coordinating Council. The Center may supply statistics and background papers to support the creation of model legislation, and conduct original research on the status of long term care in Texas.
- The Center is providing legislative training to legislators and their staff related to long term care needs in Texas. The Center will seek model legislation in other states which may be useful in Texas.
- The design of a uniform geriatric assessment instrument is another project being handled by the Center. Such a tool would provide a statewide minimum data base on elderly in Texas. The Center will study the development of such an instrument designed to be analyzed by computer.

# Information Dissemination

Research and information gathering are merely academic activities unless the knowledge gleaned from those studies is given to people who can put it to use. The Southwest Long Term Care Gerontology Center has a major commitment to disseminate information on topics of long term care to those who can use it.

The distribution of that information is produced in a variety of forms for a variety of audiences, from a technical paper for an academic researcher to a videotape designed for grown children concerned with an aging parent.

**Workshops And Classes**

Workshops, training classes and speaking engagements offered the Center staff the opportunity to present information in a face-to-face situation, with the added benefit of immediate feedback and question and answer sessions.

- The staff was involved in numerous workshops on topics ranging from "Tapping Resources on Alzheimer's: Where Do You Go?" for an SWSA meeting, to a DRG Workshop for the Arkansas Aging Conference.
- Training was provided to both professional practitioners and interested lay groups. A training session was held for a lay group at a Dallas church interested in promoting informal family caregiver support groups. The Center cosponsored training of a more technical nature in a conference involving 135 physicians, nurses, social workers and nursing home administrators, on "Assessing The Elderly: Issues and Answers."

**Videotapes**

Videotapes provided another vehicle for transmitting information when a situation called for visual explanations. Videotapes were utilized to help supplement written material in various replication projects.

- For example, to provide visual training in the replication of the Elderwatch rural service program, video cassette materials are being prepared for distribution.
- Another videotape product includes a "Sexuality and Aging" videotape with a panel of experts. Much information is given and myths are discussed. The videotape is designed for audience participation follow-up.
- A videotape to be used in continuing education is titled "The Psychology of Aging." And another videotape on "Interviewing the Elderly," depicts principles involved in obtaining a medical history from an elderly patient.

**Research And Technical Papers**

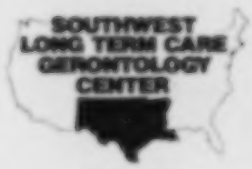
Research and technical papers for distribution to academic audiences and professionals are scheduled regularly throughout the year.

Plans call for four technical papers each year on "best practice" concepts to be distributed to all area agencies and state units in the region. Four research papers per year on current long term care research being conducted by the Center will also be distributed per year.

**Informational Papers**

Another set of regularly scheduled informational papers will be published. These will be oriented to the needs of the practitioner in the field of aging. The topics will often be the same as the above research and technical papers, but will be rewritten in a non-technical format.

# Toward Self Sufficiency




The Southwest Long Term Care Gerontology Center continually works toward self sufficiency by the development of financial resources. The Center works not only on the development of resources for its own expansion but also in the search for funding for the aging components within its region.

### Current Program Funding

The Center actively is seeking the continuation of grant funds for current activities.

- The Robert Wood Johnson Foundation Hospital Initiatives in Long Term Care Program operating with Parkland Memorial Hospital is funded until January 1987.
- The Elderwatch program is continuing with a grant funded through Levi Strauss Foundation.
- The Center continues to work on a Discretionary Fund grant for targeting resources with monies from the AoA.
- The Drug Interaction program, funded with seed money from ARCO is expected to receive additional funding.

### Future Funding

Looking towards the future the Center has set a goal to identify a minimum of $150,000 of additional funding for model programs, research and educational activities.

- To reach that goal the Center is seeking at least half of that amount from private sector funding. Requests to corporate and private foundations are being prepared.
- A Development Advisory Council Committee will advise the Center on cultivating contacts.

### Development Work For States

- To assist the individual states and area agencies in the region the Center is publishing a directory of foundations which have provided support to long term care or aging programs in each of the five states. The directories will be distributed to each state's office of aging and the area agencies.
- The Center is assisting the state offices on aging to develop resource plans which match funding with state needs. Specifically the Center will offer a training course in resource development and application preparation to the long term care network. As noted earlier, the Center has offered extensive assistance to each state in developing grant applications for their programs.

### University of Texas Resources

The Center is developing University of Texas resources to further enhance the center's stability.

- Working with the Office of Development the Center is seeking a lead foundation in the health field which can gather together appropriate foundations to consider joint of center projects.
- The Center is expanding its reimbursable service offerings to augment its income. Such services include consultations, joint grant applications and continuing education programs.

- Expanding the number of tenure positions in the gerontology program by a minimum of one-half time equivalent, and the continuation of the current four tenure positions is expected.
- An endowed chair in geriatric social work at the School of Social Work at UT Austin will be utilized for seminars featuring national lecturers brought to Dallas, Austin and El Paso.
- The School of Nursing at UT Arlington will receive the Center's assistance in developing grant applications for the geriatric nurse practitioner program.
- The Center is currently working with the Dean of the School of Allied Health Sciences to raise funds for an endowed chair or professorship in gerontology and allied health.

# Value Of The Center, Now And Tomorrow

The Southwest Long Term Care Center is finding unusual ways to serve its five-state area, and to be an active leader in the formation of long term care policy in the region. With its broad multi-disciplinary foundation and its participation in programs at the community level, the Center will continue to grow in service and influence.

**Center Consulting Work**

The Center staff regularly offers its services to community groups in consulting capacities.

- The staff spoke at a meeting of 18 city of Dallas departments supervisors regarding mental health, job performance and aging.
- A staff member participated in a program on the psychology of aging with a meeting of the Dallas Psychology Association.
- Expert testimony was given to the Texas Health Facilities planning commission hearing in Austin regarding need for a geriatric psychiatry unit to be built in the Dallas area.
- A staff member serves on the Aging Committee of the Dallas County Mental Health Association.
- Presentations about retirement preparation to more than 200 employees were made for corporations, labor unions and agencies.

**Center's Legislative Role**

Seeking to play an active role in the development of legislation within each of the five states, the Center develops the necessary legislative information packages.

Training and legislative assistance is included in each of the state plans. The Center is also an active participant on special governor's committees on long term care in each state.

**Library Facilities**

For research the Center has at its disposal the full resources of the University of Texas Health Science Center Library.

- Designed for use by the Southwest Medical School as well as the School of the Allied Health Sciences, the library contains 179,386 volumes.
- Included in its 2,476 serial titles are numerous geriatric and gerontological journals, as well as medical journals which from time to time have relevant articles.
- Also available are 3,089 nonprint materials including films, video cassettes, and slides.
- Based at the Center is the Library on Aging which houses the cumulative holdings from the past 20 years from the regional Administration on Aging office.
- The Library on Aging contains several major journals and books in the aging field, final AoA grant reports from 1969-1981, agency training and program development handbooks, and government publications covering a broad range of areas related to the elderly.

**Center In The University System**

The Southwest Long Term Care Gerontology Center is an integral part of the University of Texas system. Operating under the President of the University of Texas Health Science Center at Dallas, the Center is located in and shares offices and staff with the Gerontology Services Administration program.

The Health Science Center plays a major role providing expertise and training for the SLTCGC.

Through the University system, two other institutions play key educational roles. The School of Social Work at UT Austin provides the expertise in gerontological social work. And the School of Nursing at UT Arlington offers direction in the discipline of geriatric nursing.

**Future**

By the year 2004 more than 25 per cent of the population in this five-state region will be over the age of 65. A significant portion will be classified as "old-old", placing heavy demands on long term care services.

The Southwest Long Term Care Gerontology Center's mission is to take a leading and creative role in preparing the region to meet the future needs of the growing elderly population, whether they reside in the community or in long term care facilities.

The Center is raising questions in the present which will have to be answered in the future.

Mr. KILDEE. Thank you very much.

If the DRG's were kept in place without any substantial change, it would appear then that we should be better funding the title III programs of the Older Americans Act.

Ms. WILSON. Yes.

Mr. KILDEE. Pressure is clearly being put on those programs because of this early discharge from the hospitals.

Ms. WILSON. Yes.

Mr. KILDEE. I've seen that in my own family. My mother, who is 85 years old, last year, in August—just about a year ago—fell and was hurt very badly. After a certain number of days in a hospital, she had to leave. Were it not for some programs, like the Meals-on-Wheels Program specifically, there is no way that she could have ever returned to her home when she did.

She pays for that meal. That's one source of the funding for it—her own contribution. But she was just happy that the program existed, because that made it possible for her to return home.

Having seen it first-hand, I began to observe other people. What clearly emerged is that, very often, older people, when they are feeling ill or have suffered an injury, don't eat adequately, and therefore their health further deteriorates. But if you can get that balanced meal somehow into the home, then they begin to recover.

It would seem that the Government of the United States could have done a better job if, indeed, there is any good rationale for the DRG's—it they would have given more money for these other programs, because, clearly, utilization has increased for these other programs as people are discharged from the hospitals earlier.

I do editorialize a bit, as some of you who have attended my hearings before know. I mentioned that these programs have been pretty well level-funded now for about 5 years without any significant increase while, at the same time, other departments of Government have enjoyed massive increases.

It could be argued by advocates for those other departments—let's take a case in point, the Pentagon—it could be argued by some that those increases were needed. What bothers me though is that all the increases that Cap Weinberger has gotten for the Pentagon have come not from increased revenue—because revenues have been cut in that period of time—but from taking the money from other programs, including the Older Americans Act.

So not only have they about doubled the Pentagon's budget over the last 5 years, but they've gotten the funds not from saying to the American people, "Listen, we have to have taxation in order to protect our country." Instead, they got it from the School Lunch Program, the Older Americans Act, and from the WIC Program. That's how Cap's gotten his money.

It's not a conjecture on my part; it's clear and simple that he's gotten his money, aided and abetted by Dave Stockman, from the programs that really address the basic human needs of people in this country.

People like yourself who are both expert in the program and not ashamed to also be known as advocates for the program really have to say,

Hey, we need funds for our programs, too, and if you need to increase your budget, don't do it by taking money from our budget, which addresses the most basic human needs of people in this society.

Your study is, I think, going to be extremely valuable to the Congress of the United States. For that reason, I'm going to make sure that this committee and its staff pore over that study and lift from it shamelessly some of the findings in that. We thank you for that very, very much.

Ms. WILSON. That's what it's for.

Mr. KILDEE. Before I go on with questions, I would like to recognize the ranking minority member of this committee—it's a joy to have him because he has the same sensitivity to people. If I were to choose someone to be ranking, this would be the person I would choose, Tom Tauke from Iowa.

Mr. TAUKE. Thank you, Mr. Chairman.

I just was listening to your observations. There was one other group that aided and abetted some of the changes in policy, and that's the Congress of the United States, which voted for all of the——

Mr. KILDEE. There is some collective guilt.

Mr. TAUKE. Yes.

In any event, this apparently is Medicare day on Capitol Hill. It is the 20th anniversary of Medicare, as you know. I serve on the Aging Committee, where we are having a hearing. I'm also on the Health Subcommittee of Energy and Commerce, where we are about to begin a markup of the reconciliation on Medicare, part B. So I might have to leave shortly in order to do some good over in that committee, or at least we hope that we will do some good.

But I am very intrigued by your study and your opening comments, which I found to be very useful. You are a very good witness, I might just say parenthetically.

There are a couple of things that I wanted to ask about. The first is, I represent a State that has a large rural population, the State of Iowa, and I wonder if you have noticed any particular problem in rural areas or in the inner city areas, in the sense of the very intense population centers and the very sparsely populated centers, relating to the provision of services for those who are released from hospitals.

Ms. WILSON. It's easiest to speak about the rural areas, and there are obviously issues associated with the availability of services as well as access to them.

If you talk to some area agency people in terms of services, they say, "Well, first we have to go out and develop those services to meet this increased demand, and then we have to get people into those services and access to them."

So actual availability of a wide range, a continuum, of services is an important issue in terms of the rural populations that we have been studying at least.

Mr. TAUKE. Could you give us any indication as to how many area agencies in the country—what percentage—even offer the continuum of services that you would consider adequate?

Ms. WILSON. My expert is behind me.

Mr. TAUKE. Would half of them do it? Would a quarter? two-thirds?

Ms. GORSHE. The definitions are quite different with the continuum.

Mr. TAUKE. Perhaps you could give your name.

Ms. GORSHE. My name is Nancy Gorshe. I'm assistant director with the National Association of Area Agencies on Aging. We do have a national data base on aging that collects data annually from area agencies, from which my opinion will come, but I stress that it's an opinion, and we can get some more specific data to you.

I would say that the area agencies—about half of them, indeed—do have what we would call a full continuum of services available and that some of the biggest gaps would be in the rural areas, from being able to develop services.

It has to do with what's available from other contractors, other agencies, types of services that are available, whether there's a hospital in the community, whether an existing home health agency exists in the community; there are many variables. But from their reporting, they themselves report about 50 percent.

Mr. TAUKE. So about half of the area agencies on aging would have a continuum of services. Would that half of the area agencies cover half the population, or two-thirds of the population? Could you speak to that question?

Ms. GORSHE. I would love to defer to getting some better information to you, because we can tell you that. You know, the largest area agencies cover the largest number of people in New York, Los Angeles, and Florida.

Mr. TAUKE. Would those large area agencies tend to have the continuum of services?

Ms. GORSHE. Yes.

Mr. TAUKE. Perhaps one of you could tell us, in the areas where you do have an area agency on aging that offers a continuum of services, do the elderly patients who need those kinds of services use them? Do they seek them out? Are they readily available to them?

Ms. GORSHE. I think Laura points out a very good point about access. Access to services finding out about them has been a very difficult process, and getting adequate information out depends a lot on the entire community, on working with hospitals, on assistance from hospitals at discharge time, informing people about the connections.

Case management—care management—has become a word I'm sure you're more and more familiar with. It's a social work term from the past that has become more popular simply because it's trying to help people through the maze.

It's difficult to tell you the numbers of people who aren't getting services that need them, because we may not have identified them yet. But, you know, the Older Americans Act requires information and referral, outreach services, and now case management under this recent reauthorization.

So we still think that a critical part of the Older Americans Act is indeed identifying the appropriate clients and controlling, targeting, which services are most appropriate to those persons, since indeed we don't have enough funds to provide services to all older people.

It would be difficult to answer that about who is not getting services at this point, because we may not know about all of them, but there is a definite effort always.

Mr. TAUKE. What kind of cooperation do you see from hospitals? In my district, some hospitals are doing a very good job in attempting to coordinate with other services in the community. In fact, we'll hear from a witness later on this morning who represents a hospital that is making good efforts in that area. I also have some that I don't think are doing much.

Can you give us any indication as to what the general picture is across the country relating to hospital involvement?

Ms. WILSON. I think it's mixed, depending on what their attitude is. Some hospitals want to provide those services themselves, for obvious reasons, in terms of their own ability for cost containment. Others see that as a reason to work with the community and make best use of services.

Certainly in the area of public hospitals there is a tremendous push to make use of services in the community and provide good linkage, and there's an excellent example of that in Dallas with Parkland Memorial Hospital, our county hospital.

Mr. TAUKE. Did you have something to add?

Ms. GORSHE. I would also say that, again, going back to the Older Americans Act, area agencies are required to coordinate with all community providers of services, which includes the hospitals. So the area agencies, indeed, have increased their attempt to coordinate with local hospitals, and from that point it would depend on what the hospital itself perceives its relation with the community.

Mr. TAUKE. From the perspective of the U.S. Congress, what is the one thing that we could do that would best improve the situation? What can we do to help out?

Ms. GORSHE. On the top of the list, I would say increasing appropriations for title III(b) of the Older Americans Act for this particular situation. Coordination between the Medicare Program and the Older Americans Act Program has not been looked at, and what has happened, I think accidentally, has been that title III(b) programs have become a gap filler for Medicare programs, that those services that are not reimbursable under Medicare under this change with DRG's.

So, at this time, I think the in-home community services are critical, are important for maintaining people in their homes, and I think increased appropriations are very necessary.

Mr. TAUKE. Recognizing the tight budget, I'll also ask you for a second suggestion, besides increasing appropriations.

Ms. GORSHE. I would go back to the coordination between the two programs—between Medicare and the Older Americans Act—and possibly looking at the existing Medicare Program and the funding sources there and the allowable services under Medicare, that indeed some of the personal care, the homemaker chore services that are not reimbursable now or for limited amounts of time should be looked at for extension.

Mr. TAUKE. Thank you, Mr. Chairman.

Mr. KILDEE. Thank you, Mr. Tauke.

I guess this is the same question Mr. Tauke raised. While I, obviously, would support increased funding for title III—I think that

has really been level funded too long—other than increased funding for title III, do you have any suggestions as to how we could make changes either in title III or in the Medicare DRG system to better respond to the needs of the people?

This committee is open at any time. I know very often some of our questions are things for you to ponder on and get back with us at some other time. It's going to be difficult this year since apparently the budget process broke down again last night between the White House and the Senate. It's going to be difficult to substantially change the parameters that the House set for the budget this year.

The problem we have created here is that the DRG's may be defective in themselves, and/or they may be defective because of transferring the responsibility to title III. I think that's what we have to try to really get a good handle on—whether there are some defects in DRG's that we should try to remedy or even chuck the system, or try to see how we can take care of the increased utilization that, apparently, from the Texas study, has taken place now in title III as a result of people being discharged earlier from hospitals.

Any help that can give us in trying to figure out how we can make sure these people receive at least the same level of care they were receiving before under this combination of DRG and title III would be greatly appreciated.

I have seen individuals out there who appear not to be receiving the same level of care. It seems to me that the left hand and the right hand of DRG's and title III are not watching one another that closely.

Ms. WILSON. In these times of limited budget, I think it's essential that you are able to document and back up some of the things that we know from visiting some of our friends and some of our family are going on in terms of quality of care and changes and shifts in terms of what is happening with the Title III Program.

This study is just a start in terms of the kinds of things that need to be done, and we're now in the beginning phases of what I think will be much more valuable and increasingly valuable, and that is looking at clients or patients themselves and following them for a period of time back into the community, because, as you mentioned, it isn't just the initial discharge from the hospital and the initial obtaining of services or access to those services but the fact that over time there are going to be increasing numbers of changes as they are back into the community potentially too early that, after the initial services, they'll need more services, they'll be readmitted to hospitals more often, or they'll need different mixes of services over a several months period, and we'll only know at this point in time about the initial discharge.

So to back up any changes, whether they be additional funds or reallocation of current funds, you're going to need to have some of this kind of data to back up those kinds of requests.

Mr. KILDEE. Let me ask you this then. Do you think that the Government of the United States—that is, the total Government of the United States—adequately perceived what might happen as a result of these DRG's and the effect upon, say, the title III programs?

Ms. WILSON. From a research perspective only, it's very clear that that wasn't true, because in order to look at this you needed to have some kind of pre-DRG data, some kind of data that indicated whether the program was or was not having an impact, and there is almost no way to do that except retrospectively in terms of collecting that data and having it be validated.

We have been casting about for some time for these several methodologies, and I think just in terms of a research perspective the lack of planning to be able to have data to show what was happening to the DRG Program is significant.

Mr. KILDEE. Do you think it might have served us better had we had a more comprehensive pilot program rather than do this in general and then find out what the results may be with a general program?

Ms. WILSON. A well established pilot program that took into account national distribution, urban and rural, et cetera, would have been a good plan.

Mr. KILDEE. Perhaps in a State or part of a State we might have tried to do it in that fashion and seen what the effects might be on the other programs. Maybe we can learn from that in the future, that we just don't change things massively and then not have knowledge as to how that might affect other programs.

Ms. WILSON. In times of limited funds, sometimes research is the first to go, and I'm not sure that that's what needs to happen.

Mr. KILDEE. In your testimony, Doctor, you mention that local agencies' priorities are often determined by both congressional budget allocations and congressional restrictions. Do you feel that we could change some of these legislative restrictions to give more flexibility?

Let me give you an example. In the 1984 amendments to the Older Americans Act, we increased the ability to transfer funds from congregate meals to home-delivered meals from 20 to 30 percent. Do you think that type of flexibility would be helpful in the title III programs?

Ms. WILSON. Definitely. I think that the title III programs were well developed for a particular reason that points toward preventive care, but at this point in time, given the environment the DRG's have created, we need to also think about more seriously services related to a frailer population and a population that needs to become able to return to functional status with the help of some of the title III programs.

Mr. KILDEE. Thank you very much.

We are going to keep the record open for 10 days anyway. So if you have any additional information you want to give for the record, that will be included. But even after that, we would encourage you to keep in contact with us, because it's important for us that we are able to tap the resources of people like yourself for ideas that can guide the Congress of the United States.

I don't make any pretense. I'm an advocate for these programs, and I think that's just one of the realities here in the Congress, because the chairman of the Armed Services Committee is quite a strong advocate there. So I need objective data to help me in my advocacy.

I've already decided that these programs are extremely important, but I need data from people like yourself and expertise from people like yourself.

Thank you very much.

Ms. WILSON. Thank you.

Mr. KILDEE. Our next witnesses will be a panel, consisting of Mr. Robert L. Dolsen, executive director, the region IV area Agency on Aging, from St. Joseph, MI; Ms. Ann Burgen, president of the National Association of Nutrition & Services Program Directors, Frankfort, IN; and Mr. Richard Reiter, vice president, Mercy Health Center, Dubuque, IA.

Mr. Dolsen, I'll be heading toward St. Joseph, MI, on Saturday. I am going to Stevensville——

Mr. DOLSEN. Oh, we'll be delighted to have you there. We'll take you down by the lake.

**STATEMENTS OF ROBERT L. DOLSEN, EXECUTIVE DIRECTOR, REGION IV AREA AGENCY ON AGING, ST. JOSEPH, MI; ANN BURGEN, PRESIDENT, NATIONAL ASSOCIATION OF NUTRITION & SERVICES PROGRAM DIRECTORS, FRANKFORT, IN; AND RICHARD REITER, VICE PRESIDENT, MERCY HEALTH CENTER, DUBUQUE, IA, A PANEL**

Mr. DOLSEN. My name is Bob Dolsen. I'm the executive director of the region IV area Agency on Aging, which represents the boards and the advisory councils and staff of more than 660 area agencies on aging nationwide.

I'm very pleased to be invited to speak before this subcommittee on behalf of our association. I'm particularly pleased to speak before a committee chaired by our distinguished Congressman from Flint, MI.

I'd like to commend the Southwestern Michigan Gerontological Center, particularly Dr. Wilson. It's very satisfying to have your informal findings supported by solid, empirical data, especially from a prestigious institution like the University of Texas, and we look forward to the continued work from that institution.

The ideal health care system meets three basic criteria: reasonable cost, quality care, and equitable and appropriate access. As long as third-party payers were willing to pay the going rates without protest, consumers—almost all consumers—were reasonably assured of comprehensive quality health care, and both provider and consumer believed that health care was a charitable service to which we were all entitled.

When cost containment became the overriding concern of the purchasers a few years ago, not only did we find a struggle between provider and consumer regarding who would bear the burden of cost containment but also health care became a bona fide business with all the dynamics of the marketplace.

Deregulation and its attendant competition meant that hospitals and physicians would begin to weigh the acceptance of clients, the tolerance of risk, and the offering of kinds of services against profit margins.

The DRG's divided physicians, medical procedures, and patients into winners and losers, and hospitals have been moving to divest

themselves of the losers. It means to patients that health providers felt no longer an obligation to serve every person, every affliction, in the most comprehensive way possible. It meant that maximum quality of care and universal appropriate access are now assured only by the market forces and purchasing power, and it has much to do with the problems we discussed today.

The area agencies on aging, in our efforts to fulfill the mandate to enable older persons to live in their own homes or other places of residence as long as possible, began early on to learn about the group now feeling the impact of the DRG's—frail, at-risk elders. Our first valuable lesson was that public policy generally consigned the vulnerable, functionally disabled elders to institutional care, and it still does.

Last March, Business Week magazine provided guidelines to the middle class on how to become eligible for Medicaid and subsidized nursing home care. The message was clear that long-term care was the nursing home and the path was through poverty. There was no reference to home care.

There was, incidentally, in this morning's Washington Post an article saying that two-thirds of all older persons entering a nursing home are impoverished in 13 weeks—destitute in 13 weeks—those are single elders—and that 80 to 91 percent of all persons entering a nursing home are impoverished within 2 years. That's a startling statistic.

It s interesting that, in spite of that, there has been such a lack of initiative in terms of developing home care, and we're very concerned about that. We also learned that this population would grow phenomenally in the next 20 years.

The second lesson we learned is that the intent and objectives of the Older Americans Act are at odds with its appropriation pattern. Services most effective in persons remaining in their own home are in-home services, but AAA's are forced to list congregate nutrition first in our plans since the categorical appropriations dictate our priorities.

Individual area agencies have, whenever politically possible, shifted funds to in-home care and to home-delivered meals, and the National Association of Area Agencies has pleaded with Congress for the past four reauthorizations to increase subtstantially appropriations for title III(b)—that is, supporting services—and title (c)(2)—home-delivered meals.

The third lesson we learned is that the problems of at-risk elderly are multidimensional and cannot be addressed adequately by a single-service provider system. Individual circumstances differ markedly, requiring varying degrees of health care and a variety of social services, with varying degrees of informal family support.

An inappropriate mix can be inordinately costly and unnecessary, on the one hand, or dangerous to the older person's welfare, on the other hand. In the market system, the potential for both abuses is growing.

I might mention, too, that there is a tendency for all of us to fall into the pattern of what Abraham Kaplan called the law of the instrument, and that is, we tend to see those problems in the world through our own eyes and our own experience.

He called it the law of the instrument, and he used as an analogy that you give a small boy a hammer and he'll think that everything in the world needs pounding. That's often what happens with the service provider system—that if you ask the Legal Services people what older people need most, they'll tell you legal services; and if you ask a person in home health what they need, they'll tell you home health; and if you ask a homemaking agency, they'll tell you it's a homemaker service. Consequently, there's that tension.

One thing that area agencies have discovered—because we're not out to deliver direct services—is that usually a mixture of all those things, put together and coordinated so that it relates to the unique circumstances of that older person.

The final lesson we learned is that by either action or design the AAA's are extraordinarily well placed to manage local, community-based, long-term care systems. We have expertise in managing contracts and monitoring services, and we can afford to be advocates without vested interest.

The DRG's do indeed release older persons from the hospital quicker and sicker, as many have claimed, but the phrase suggests, unfortunately, that large numbers are being discharged in the need of medical intervention, which is generally untrue.

It is instructive to look at what services hospitals really offer. Before the inception of the DRG's, hospitals provided more than medical care. They provided a controlled and sheltered environment for patients recuperating or gaining strength in order to function independently or for patients whose homes were not equipped to receive them in their convalescence.

For 2 days, or 1 week, or 2 weeks, the hospital would provide a clean, secure room, housekeeping, laundry, meals, help with bathing, walking, dressing, and toileting, as well as constant surveillance, combined for a period of patient preparation, or of respite, for the patients' families.

With the implementation of the DRG's, hospitals have moved quickly to develop the pattern for prosperity under the new system—that is, more admissions and shorter stays—and the key is to undertake all medical procedures as quickly as possible after patient entry, and discharging as soon as possible, foregoing all those extra activities associated with the recuperative stages. Some are discharged with some post-medical procedures to be performed in the home.

With the increasing restrictions on Medicare home care, the burden often falls squarely on the patients in the Older Americans Act network. Area agencies on aging across the Nation have felt the surge in demand for in-home skilled nursing and home health aides.

But the preponderance of the demand for Older Americans Act services has emanated from the nonhealth needs of older discharged patients. The hospital DRG's effectively distill the medical procedures from general care from the social support services they once provided.

While permitting full treatment of an illness, DRG's no longer allow the flexibility for support to compensate for the debilitating circumstances caused by the illness. There is a decline in the test to be on the safe side. There are fewer physicians keeping mom

over a day or two until the family can get ready, and there is very little keeping dad a day or two until he gains a bit more strength.

For example, an 80-year-old client of our case management project was discharged to his home after cancer surgery and a colostomy; a 20-year victim of Parkinson's disease, he was released to the care of his 75-year-old sister who suffers from arthritis of the spine. His medical treatment, excepting some nursing for the colostomy was completed, but both he and his sister were physically unable to meet his personal needs—bathing, eliminating, turning, dressing, et cetera—activities not Medicare reimbursed. Only our Older Americans Act resources saved him from nursing home admission.

Patients receiving hospital care for stroke, heart disease, or hip surgery are discharged to their own resources to conduct the activities of daily living which their post-medical conditions often preclude.

The DRG's have placed the AAA's in a race for development with nursing homes, nursing homes which are now fighting the certificate of need process in order to build substantially.

We have learned, as research has substantiated, that while nursing homes are considered health care institutions, health care is not the primary reason for which people go into nursing homes. The primary reason is difficulty with ordinary activities of daily living and the lack of affordable support services in the home to make the activities of daily living possible.

While an elder may need some health care upon discharge from a hospital, the need for the health care usually diminishes in a few months, but if home support services are not in place, a client may be a candidate for a nursing home regardless.

Significantly, when health care eligibility runs out and private funds are inadequate, the fates of vulnerable elders rise or fall frequently on the resources of the Older Americans Act. The alternative is often impoverishment in the nursing home.

The DRG's also have a profound impact on the families of older patients. The research of Elaine Brody of the Philadelphia Geriatric Center has warned us that families—adult daughters particularly—can reach a breaking point when they are overextended. The early release of at risk elders frequently traumatizes families and makes immediate demands on them they are neither emotionally nor physically equipped to meet.

Our practice is to provide immediate professional care for the older person and begin counseling and training for the family caregivers, pacing them toward the assumption of responsibilities.

Perhaps the most immediate and confusing task confronting an older person with multiple and complex problems and her family is negotiating the increasingly competitive health care system. Some providers have much professional integrity, but others can be exploited.

Home skilled nursing care costs range considerably, depending upon reimbursement structures and what the traffic will bear. More and more patients receive care unnecessarily until the end of their Medicaid eligibility, and expensive health care is sometimes provided where much less expensive social support services or even trained family members would do.

Dr. Rosalie Kane of the Rand Corp. stated, "We have a bad track record with nursing home care, and there is little reason to expect home care to be different. It will simply be harder to observe."

While some have suggested that licensing and certification of home care will be the answer, we must remember how ineffective they have been in maintaining nursing home standards. Home health is funded with less utilization review and monitoring than nursing homes, and the potential for abuse is just as great.

Area agencies in many States have developed case management systems designed to coordinate activities on behalf of older persons, and they also can manage and monitor services.

Incidentally, in regard to Mr. Tauke's response, in our case management system we gave up case finding 2 years ago with the inception of the DRG's because we were already overwhelmed. When we talk about getting the word out that a service is available, when you're already at capacity, it doesn't pay to get it out just to turn people down. Right now, our case management project works primarily with physicians and discharge planners. We don't bother to let the public know about it. We just deal with those who can make the direct referral.

The DRG's, contrary to public perception, are currently providing a windfall for many hospitals who have shifted the responsibility for the social support of recuperating older patients to the aging network. If some hospitals are in financial trouble, it is more likely the result of the aggressive marketing by other hospitals to capture the high revenue clients under the DRG system.

Some enterprising hospitals have even entered the home care field to compound their revenues. Because home health care is not under the DRG's, it is very attractive and can be very profitable, especially profitable if client flow and mix can be controlled. For every procedure the hospital home health project can undertake in the home instead of the hospital, it will be paid again by Medicare because the DRG payment for inpatient care will not be diminished. Further, the hospital home care project can sift for the most profitable clients.

The primary consequence of the DRG's to older adults has been the shifting of the responsibility of care from the acute care system—that is, the hospital—to the Older Americans Act system which is trying to assume this enormous responsibility with no increase in funding.

AAA's have heightened campaigns to increase donations to make funds go farther. We have rationed the units of service so we can serve more of the growing numbers of potential clients. We have shifted our nutrition funding as far as politically possible from congregate to home-delivered meals. We have made greater demands on families to assume responsibility for personal care, and the burdens continue to grow at astounding rates.

The number of calls from clients whose Medicare funding has run out continues to grow. Service providers overspend, knowing that they face a crisis at the end of the fiscal year, and more and more are turned away.

In my region, harried discharge planners without the home care option have looked more and more to nursing home placement, the list for which has extended from a 1-week waiting period to a 22-

day waiting period. The Detroit Area Agency on Aging has amassed a home-delivered meal waiting list of 3,000 before they gave up taking names.

Most of us gave up waiting lists long ago since we know, after a week or so, clients have been placed in a home, found a way to muddle through, suffered a complication or relapse, and were readmitted to the hospital or even died.

We try not to become preoccupied with those we turn away, but we are acutely aware that the Older Americans Act system is the only Federal resource available to those suffering from chronic conditions, the care for which cannot be paid by Medicare and who are not poor enough for Medicaid.

It is therefore with dismay we see Congress looking to the expansion of the Medicare system to address the DRG problem. Not only will Medicare, which is acute health care directed, have minimal impact, but it will also be inordinately expensive. Medicare will not have the flexibility to provide basic social supports, such as homemaking, chore services, home environment alteration, home-delivered meals, legal services, and counseling, nor those family support services such as respite care, day care—those activities which will still be provided through the aging network—and Medicare home care, however modest the impact, will draw down heavily from the Federal Treasury.

One unit of home health care up to 2 hours of care ranges usually between $40 and $50. Our local AAA care management project, capitalizing on the competitive market through a direct purchase system, can buy the identical service for as low as $7 an hour, performed by the same people through the same agency but with a greater assurance of quality and with much less opportunity for abuse since we set the frequency and duration of the care and monitor the performance.

Area agencies can restore appropriate access and quality of care to home care, access and quality lost to the marketplace under the DRG's.

While we endorse Congress' efforts to make Medicaid waivers more accessible to the States, without an increase in funding for the Older Americans Act the message is clear; personal poverty is the easiest road to care for the stricken elderly.

Other congressional efforts aim at the supply side approach, offering tax credits to families willing to care for aged parents in their own homes. Our experience with families indicates that financial incentives would have no appreciable effect on family behavior. Families' greatest concerns center on their ability to sustain themselves emotionally and socially, not on the financial concerns. This was confirmed by research efforts sponsored by the Health Care Financing Administration and the Philadelphia Geriatric Center.

We can reform the Medicare system, but it won't solve the problem. We can ease the restrictions on Medicaid, but it won't solve the problem. We can provide tax credits, but it won't solve the problem.

The area agencies on aging can demonstrate through their past efforts their ability to counteract efficiently and effectively the

force of the DRG's on the growing numbers of our older old citizens, but numbers have already far exceeded our capacity.

We have asked in the past that funds for the Older Americans Act be appropriated up to the authorized levels, particularly in titles (b) and (c)(2). Although $83 million may appear a large increase in these times of budget austerity, in the wake of the shifting of billions of dollars, it would be a very modest cost to ameliorate the devastating effects of what was designed to be a primary cost saving effort, the Medicare prospective reimbursement system.

The fact that Chairman Kildee, our distinguished Congressman from Michigan, and the rest of this subcommittee have seen fit to hold this hearing at this time is most heartening. I hope your deliberations lead you to introduce the appropriations at the authorized levels. Many frail older persons whose well-being hangs in the balance would be very grateful.

Thank you.

[The prepared statement of Robert L. Dolsen follows:]

PREPARED STATEMENT OF ROBERT L. DOLSEN, EXECUTIVE DIRECTOR, REGION IV AREA AGENCY ON AGING, INC.

Chairman Kildee and other distinguished members of the Subcommittee on Human Resources, I am Bob Dolsen. Executive Director of the Region IV Area Agency on Aging and a member of the National Association of Area Agencies on Aging, which represents the Boards, Advisory Councils, and Staff of more than 660 Area Agencies on Aging nationwide. I am pleased to be invited to speak before this Subcommittee on behalf of our Association with regard to the impact of the Medicare prospective reimbursement system on the Older Americans Act Network.

The Medicare prospective reimbursement system, now in effect for slightly less than two years, combined with the deregulation of the health care system, is the third profound change in health care our nation has faced in this century, following in importance only the growth of the private health insurance industry after World War II, and the passage of Medicare and Medicaid in 1965. While this may appear as overstatement now, as DRGs become pervasive in non-Medicare payment systems, the fundamental purposes of our entire health care system will be overhauled.

Health care systems, indeed all human service systems, aim to meet three basic criteria: (1) reasonable cost, (2) quality of care, and (3) equitable and appropriate access. As long as the third party payers were willing to pay three "reasonable and customary charges" in accordance with the providers' judgement, we has little reason to expect providers to cut back on the quality or comprehensiveness of care, or to expect them to deny care to anyone whose third party payer gave small thought to cost containment. But as cost containment efforts, such as the DRG system, were implemented, there grew some legitimate concern that some people may be provided inadequate service or be denied essential service altogether.

The persons most significantly affected by the DRGs are the target population of the Older Americans Act, and the Area Agencies are in a singular position to provide some insight into the impact of the DRGs. At the outset we can assure you the effect has been profound and will become more devastating if something is not done.

It is also important to point out that much of the problem existed long before the DRGs were implemented, but that the DRGs have compounded the problem appreciably and made it more visible.

Since the mandate of the 1973 Amendment to the Older Americans Act was for Area Agencies on Aging to "establish comprehensive, coordinated systems of services to the aging" which would "enable older persons to live in their own homes or other places of residence as long as possible," we began early on to learn about the group now feeling the impact of the DRGs, the frail, at-risk elders struggling to live independently in their own homes.

Our first valuable lesson was that public policy generally consigned the vulnerable, functionally disabled elders to institutional care. In spite of the wishes of the vast majority of them to stay at home, and the fact that a compelling case could be made showing lower costs for many instances of home care, public perceptions and political power pushed policy toward institutionalization.

As recently as last March, *Business Week* magazine in its "Personal Business" column provided guidelines to the middle-class facing long term care problems on how to use trusts to become eligible for Medicaid and publicly-subsidized nursing home care. The message was clear—the answer to long term care was the nursing home and the path to the nursing home was through poverty. There was no reference to home care.[1]

We have learned also that this population would grow phenomenally in the next twenty years, especially those over 75 years, of whom over fifty percent are limited in activity because of one or more chronic conditions. For the last several years we have taken up the banner of these frail, at-risk elderly and directed much of our activities toward meeting their needs, often at our own risk politically.

The second lesson we learned is that the intent and objectives of the Older Americans Act is at odds with its appropriation pattern. While facility-based, congregate services meet a legitimate need, the services most effective in helping persons remain in their own homes are in-home services. Although surveys of needs in my own region reveal consistently that our resources should be directed toward in-home support for Activities of Daily Living, we invariably list congregate nutrition first in our plans since the categorical appropriations dictate our priorities.

While we recognize the importance of congregate nutrition and senior centers, the most visible and politically salable programs, we also believe that in-home care for the functionally disabled elders, our most silent, suffering constituency, should be given greater emphasis. Individual AAAs have, whenever possible politically, shifted funds to in-home care. And the National Association of Area Agencies on Aging, has pleaded with Congress for the past four reauthorizations to increase substantially appropriations for Title III-B, supporting services, and Title C2, home-delivered meals.

The third lesson we learned is that the problems of the at-risk elderly are multidimensional, and cannot be addressed adequately by a single service provider system. Individual circumstances differ markedly, requiring varying degrees of health care, nutritional care, social support care, legal advice, psychological counseling, adaptation of the home environment, nutritional services, transportation, and chore services. They permit varying degrees of informal family support and demand varying degrees of professional participation. An inappropriate mix can be inordinately costly and unnecessary on the one hand, or dangerous to the older person's welfare on the other. In the increasingly competitive, deregulated health care system, with some agencies survival-threatened and others aiming at market-dominance, the potential for both abuses is growing.

The final lesson we learned is that, by either accident or design, the AAAs are extraordinarily well-placed to manage local community-based long term care systems. While we have occasionally chafed at the rigid OAA restrictions against direct service delivery, in the coordination of home care, the prohibition has been extraordinarily helpful. It has given us expertise in managing contracts and monitoring service delivery performance; it has given us the freedom to be advocates for older persons when the interest of the clients and those of the service providers conflict; and it placed us in a unique position to develop a system-wide perspective to spot the weaknesses and the potential in services and resources.

The AAA Network, combining its resource management with its planning and coordinating, can, like no service provider, assure cost containment, quality of care, and appropriate access in services to the aging. And it is the only existing nationwide system flexible enough to develop an integrated, client-oriented response to the DRGs.

The DRGs do indeed release older persons from the hospital "quicker and sicker," as many have claimed, but the phrase suggests, unfortunately, that large numbers are being discharged in need of medical intervention, which is generally untrue. Before the inception of the DRGs, hospitals provided more than medical care; they provided a sheltered and controlled environment for patients recuperating or gaining strength in order to function independently, or for patients whose homes were not equipped to receive them in their convalescence. For two days, three days, a week or two weeks, the hospital would provide a clean, secure room, housekeeping, laundry, meals, help with bathing, walking, dressing, and toileting, as well as constant surveillance—combined for a period of patient preparation or of respite for the patient's family.

With the implementation of the DRGs, hospitals have moved quickly to develop the pattern for prosperity under the new system—more admissions and shorter

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[1] Donald H. Dunn, editor, "Personal Business," *Business Week*, March 11, 1985, pp. 123-124.

stays. The key is to undertake all medical procedures as quickly after patient entry as possible or on an outpatient basis, and discharging as soon as possible, foregoing those activities associated with the recuperative stages.

Some are discharged with some post-medical procedures to be performed in the home. In some cases Medicare or Medicaid will cover the non-DRG in-home procedures. But with the increasing restrictions on Medicare home care, the burden often falls squarely on the patients . . . and the Older Americans Act Network. Area Agencies on Aging across the nation have felt the surge in demand for in-home skilled nursing and home health aides.

But the preponderance of the demand for OAA services has emanated from the non-health needs of older discharged patients. The hospital DRGs effectively distill the medical procedures from general care. While permitting full treatment of an illness, DRGs no longer allow the flexibility for support to compensate for the debilitating circumstances caused by the illness. There is be a decline in "extra tests to be on the safe side," there are few physicians "keeping Mom over for a day or two until the family can get ready," and there is very little "keeping dad a day or two until he gains a bit more strength." For example, an 80-year-old client of our AAA Case Management Project, was discharged to his home a week after cancer surgery and a colostomy. A 20-year victim of Parkinson's Disease, he was released to the care of his 75-year-old sister who suffers from arthritis of the spine. His medical treatment, excepting some nursing for the colostomy, was completed. But both he and his sister were physically incapable of meeting his personal needs—bathing, elimination, turning, dressing, etc., activities not Medicare reimbursed. Only our OAA resources saved him from nursing home admission. Patients receiving hospital care for stroke, heart disease, hip surgery care are discharged to their own resources to conduct the activities of daily living which their post-medical conditions often preclude. In the past two years our AAA in St. Joseph, Michigan, has shifted the emphasis of our home care funds from home health aides to homemaking services, non-health related services.

We have learned, as research has substantiated, that while nursing homes are considered health care institutions, health care is not the primary reason for which people go into nursing homes. The primary reason is difficulty with ordinary activities of daily living and the lack of affordable support services in the home to make the activities of daily living possible. While an elder may need some health care upon discharge from a hospital, the need for the health care upon discharge from a hospital, the need for the health care usually diminishes in a few months. But if home support services are not in place, a client may be a candidate for a nursing home regardless. Significantly, when health care eligibility runs out and private funds are inadequate, the fates of vulnerable elders fall most frequently on resources of the Older Americans Act, on our capacity to provide not just health care, but also chore services, housekeeping, home-delivered meals, minor home repair, counselling, day care, coordinated and delivered in appropriate proportions.

The alternative is often impoverishment and the nursing home . . . or worse.

The DRGs have had a profound impact on the families of older patients also. The research of Dr. Elaine Brody of the Philadelphia Geriatric Center has spoken eloquently to the beleaguered families of functionally diabled older persons and how they have been willing to stretch their resources. Dr. Brady has also warned us that families—adult daughters particularly can reach a breaking point when they are over-extended.

The Care Management Project in my AAA has found that the early release of at-risk elders frequently traumatizes families and makes immediate demands on them they are neither emotionally nor physically equipped to meet. Faced suddenly with the task of caring for a former authority figure, now very weak and frail, or confused, or aphasic, or incontinent, family members are often at once bewildered, fearful, and resentful.

Our practice is to provide immediate professional care for the older person, and begin counseling and training for the family care-givers, "pacing" them toward the assumption of responsibilities.

It is important to delineate the division of service appropriate to the family and to the community care-giver. The role older people usually expect from their families is that of the provider of emotional support-visiting, calling, providing affection and encouragement, giving personal attention being available in emergencies. We separate these emotional supports from formal support services—meals, health care, cleaning, and home maintenance tasks. The family may perform such tasks as handyman work, mowing lawns, shoveling snow, washing windows, etc. on an intermittent basis, but it is a rare family which can sustain total support care on a continual basis without serious erosion of relationships, and it is those routine activities

the Aging Network must supplement to prevent family breakdown, and prevent premature institutionalization or death for aged parents.

In a study by the Levinson Policy Institute on severely disabled patients discharged from chronic care institutions in Boston, it was found that the longer families had to carry on without supplemental help, the sooner they wore themselves out—with the result that hospitals were increasingly forced to place such persons in nursing homes, since no supplemental help was available to the elderly children.

Dr. Robert Morris, of the Institute, concluded:

"What this comes to is that the absence of supplemental care services to help a family out made it impossible for families to carry on the kinds of care responsibilities which they were willing to undertake but which they were no longer able to continue without some supplement assistance."[2]

Perhaps the most immediate and confusing task confronting an older person with multiple and complex problems and her family is negotiating the increasingly competitive health care. Measures to permit Medicare and Medicaid to subsidize health care in the home have created another problem, one common to all third party payee systems. When a single local home health service provider operated a modestly funded project, there was little potential for abuse. But today competition is keen, and some providers turn on the hard sell for clients. Some providers have much professional integrity, but others are exploitive. In our region, home skilled nursing care costs range considerably. There are more and more of patients who receive care until the end of their Medicare eligibility, and then recover miraculously when funding runs out. And expensive health care is sometimes provided where much less expensive social support services or even trained family members would do.

Dr. Rosalie Kane, of the Rand Corporation, in her studies of long term care, sees a quality assurance scandal brewing in home care:

"We have a bad track record with nursing home care, and there is little reason to expect home care to be different. It will simply be harder to observe."[3]

While some have suggested that licensing and certification of home care will be the answer, we must remember how ineffective they have been in maintaining nursing home standards. Home health is funded with less utilization review and monitoring than nursing homes, and the potential for abuse is just as great.

Area Agencies on Aging in many states have developed case management systems designed to coordinate services on behalf of older persons. Without the vested interest inherent in service delivery, AAAs can manage and monitor services in accordance with client need rather than in accordance with the reimbursements which enhance agency profitability, and can prevent much of the abuse.

The DRGs, contrary to public perception, are currently providing a windfall for many hospitals, who have shifted the responsibility for the social support of recuperating older patients to the Aging Network. A phenomenon we are witnessing around the country is the cutting back of the overhead associated with vacated hospital beds, without the commensurate loss of revenue. Nurses' aides and LPNs are becoming endangered species as hospitals narrow their nursing activities to those performed appropriately by RNs.

If some hospitals are in financial trouble, it is more likely the result of the aggressive marketing by hospitals to capture the high revenue clients under the DRG system to the detriment of those hospitals not equipped for high-powered competition.

It is instructive to look to the views of investors to ascertain best the fortunes of hospitals under the DRG system. In an article in *Financial World* financial analysts comment on the fortunes of investor-owned hospitals, but their remarks apply just as well to public and non-profit hospitals, which have adopted a similar business stance. Financial analysts Hindelong and Schaible see the DRG system "working far better . . . than many had expected it would" for hospitals:

"The [DRG] program . . . is turning out to be a boon to the well-run investor-owned hospital management companies, . . . and should bolster their already healthy bottom lines in the coming years."[4]

Some enterprising hospitals have even entered the home care field to compound their revenues. Because home health care is not under the DRGs, it is very attractive and can be very profitable, especially profitable if client flow and mix can be

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[2] Robert Morris, *Home Health Services*, U.S. Select Committee on Aging, Superintendent of Documents, Washington, D.C., 1977, p. 24.

[3] Rosalie Kane, Speech to the National Association of Area Agencies of Aging Annual Training Conference, Hyatt Regency Hotel, Chicago, Illinois, August 1984.

[4] Robert Sonenclar, "Investing in Health Care," *Financial World*, July 25—August 7, 1984, pp. 12-13.

controlled. For every procedure the hospital home health project can undertake in the home instead of the hospital, it will be paid again by Medicare because the DRG payment for inpatient care will not be diminished. Further, the hospital home care project, with its monopoly on client flow, can sift for the most profitable clients, leaving the least profitable clients to the other community-based agencies.

As the director of the largest home health agency in our region said at a hearing before the U.S. House Subcommittee on Housing and Consumer Interests last year, "A . . . difficulty with the Medicare system is that it has not encouraged cost containment, since it is a cost-based system. There is no advantage to the home health agency of remaining below the cost caps." [5]

The primary consequence of the DRGs to older adults has been the shifting the responsibility of care from the acute care system—the hospital—to the Older Americans Act system, which is trying to assume this enormous responsibility with no increase in funding. Area Agencies on Aging have heightened campaigns to increase donations to make funds go farther, we have rationed the units of services so we can serve more of the growing numbers of potential clients, we have shifted our nutrition funding as far as politically possible from congregate to home-delivered meals, we have made greater demands on families to assume responsibility for personal care, and the burdens continue to grow at astounding rates.

The number of calls from clients whose Medicare funding has run out continues to grow, service providers overspend, knowing that they face a crisis at the end of the fiscal year, and more and more are turned away. In my region, harried discharge planners, without the home care option, have looked more and more to nursing home placement, the list for which has extended from a one week waiting period to a twenty-two day waiting period. The Detroit Area Agency on Aging amassed a home-delivered meal waiting list of 3,000 before they gave up taking names. Most of us gave up waiting lists long ago, since we know after a week or so, clients have been placed in a home, found a way to muddle through, suffered a complication or relapse and was readmitted to the hospital, or even died.

We try not to become preoccupied with those we turn away, but we are acutely aware that Older Americans system is the only Federal resource available to those suffering from chronic conditions the care for which cannot be paid by Medicare and who are not poor enough for Medicaid.

It is, therefore, with dismay we see Congress looking to the expansion of the Medicare system to address the DRG problem. Not only will Medicare, which is acute health care directed, have minimal impact, but it will also be inordinately expensive. Medicare will not have the flexibility to provide basic social support, such as homemaking, chore services, home environment alteration, home-delivered meals, legal services, and counseling, nor those family support services, such as respite care, day care, those activities which will still be provided through the Aging Network.

And Medicare home care, however modest the impact, will draw down heavily from the Federal Treasury. One unit of home health care, up to two hours of care, ranges usually between $40 and $50.

Our local AAA Care Management Project, capitalizing on the competitive market through a direct purchase system, can buy the identical service for as low as $7.00 an hour, performed by the same people through the same agency, but with a greater assurance of quality, and with much less opportunity for abuse, since we set the frequency and duration of the care. [See Attachment #1.]

While we endorse Congress's efforts to make Medicaid waivers more accessible to the states, without an increase in funding for the Older Americans Act the message is clear: personal poverty is the easiest road to care for the stricken elderly.

Other Congressional efforts aim at the supply-side approach, offering tax credits to families willing to care for aged parents in their own homes. Our experience with families indicate that financial incentives would have no appreciable effect on family behavior. Families' greatest concerns center on their ability to sustain themselves emotionally and socially with the increased responsibility. Our experience is confirmed by research efforts sponsored by the Health Care Financing Administration and the Philadelphia Geriatric Center. The HCFA study, published in the *Health Care Financing Review*, revealed that family care-givers wanted more than anything else support services and some relief, some even resenting financial incentives. [See Attachment #2.] Elaine Brody from her studies at the Philadephia Geriatric Center concluded,

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[5] Donald Gillespie, Ph.D., Director, Health Care at Home, Testimony before Hearing of Subcommittee on Housing and Consumer Interests, Select Committee on Aging, U.S. House of Representatives, Holland, Michigan, June 8, 1984.

"The stress of caring for impaired elderly relatives often produces negative effects on family members. It points to the need for services to the family. It points to the need for services to the family to supplement its efforts to meet the older person's need for care." [6]

The Area Agencies on Aging can demonstrate through their past efforts their ability to counteract efficiently and effectively the force of the DRGs on the growing numbers of out older-old citizens. But the numbers have already far exceeded our capacity. We have asked in the past that funds for the Older Americans Act be appropriated up to its authorized levels, particularly in Titles B and C2. Although $83 million may appear a large increase in these times of budget austerity, in the wake of the shifting of billions of dollars, it would be a very modest cost to ameliorate the devastating effects of what was designed to be a primary cost-saving effort—the Medicare Prospective Reimbursement System.

The fact that Chairman Kildee, our distinguished Congressman from Michigan, and the rest of this August Subcommittee have seen fit to hold this hearing at this time is most heartening. I hope your deliberations lead you to introduce the appropriations at the authorized levels. Many frail older persons whose well-being hangs in the balance would be very grateful.

[Attachment 1]

## REGION 4 AAA CARE MANAGEMENT—DIRECT PURCHASE OF SERVICES POOL FISCAL YEAR 1985 STATUS REPORT

| Provider service | Current area | Units-week | November 1984 dollar bid | July 1985 dollar bid | Current match/ hour |
|---|---|---|---|---|---|
| 1. HCH: | | | | | |
| HHA | Berrien | 80+ | 8.50 | 7.25 | 0 |
| Hmk | Van Buren | 15 | 7.98 | 6.00 | 0 |
| 2. Scope: | | | | | |
| HHA | Berrien | 120 | 7.00 | 7.00 | .75 |
| Hmk | E. Cass | 80 | 6.50 | 6.50 | .75 |
| 3. Beverly: | | | | | |
| HHA | Region | 20 | 7.50 | NA | NA |
| Hmk | Berrien | 30 | 5.00 | NA | NA |
| 4. C & FS: Hmk. | Berrien | 120 | 7.15 | NA | NA |
| 5. CCCOA: Hmk. | Cass | 10 | 15.00 | 15.00 | .20 |
| 6. Cass HD: | | | | | |
| HHA | Cass | Open | 16.26 | 16.26 | 0 |
| Hmk | Cass | 20 | 15.00 | 15.00 | 0 |
| 7. Upjohn: | | | | | |
| HHA | Region | 300 | 7.45/8.4 (N) | 7.90/8.0 | 0 |
| Hmk | Region | 60 | 7.05/7.5 (N) | 7.35/7.4 | 0 |

This provider's rates are adjusted for travel over 30 miles from Benton Harbor for both services. Aide rates also increase if medication administration is involved ($9.00).

*First Service Period 11-1-84 to 6-30-85*

Seven area providers joined the pool and were available for direct purchasing. Bids ranged from $16.26 to $7.00 per unit (hour) for aide services and $15.00 to $5.00 per unit for homemaker services.

CM purchased 655 hours of aide service utilizing four providers (1, 2, 3 & 7) at an average cost of $7.60 per unit. CM purchased 681 hours of homemaker service from three participants (1, 2 & 3) at an average cost of $6.50 per hour.

*Second Service Period 7-1-85 to 9-30-85*

Currently, five providers are available. The least expensive homemaker option in the first period (#3), recently went out of business and provider #4 chose not to continue participating. Average costs are anticipated to remain stable, primarily be-

[6] Elaine Brody, "Environmental Factors in Dependency," *Care of the Elderly*, London and New York, 1977, p. 92.

cause of significantly lower service bids from provider #1. Combined average cost for those providers utilized in the first period and those planned for use in the second period equal approximately $7.05.

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[Attachment 2]

## Social and Economic Incentives for Family Caregivers

(By Amy Horowitz and Lois W. Shindelman)

The recent emphasis on developing programs and policies to support families who care for aged relatives makes it important to understand the families' receptivity to the specific social and economic incentives under consideration.

The research reported in this paper draws on the experiences of 203 individuals identified as the primary caregiver to an aged frail relative currently receiving home care or day care services in New York City. As part of a larger study of caregiving behavior, respondents were asked to rank their preferences for various service and economic support programs.

Findings indicate that family caregivers perceive service and social supports, specifically medical care and homemaker service, as more crucial than both direct and indirect financial incentives. Furthermore, the issue of economic incentives elicited an extremely negative reaction from a significant minority who refused to consider such support in their personal family situations. The analysis indicated that the caregiver's background characteristics were not critical in differentiating caregivers who select either a service or an economic incentive. Among the set of variables defining the current caregiving situation, only sex of the aged relative and utilization of home care services were significantly relted to choice of program. Respondents caring for females and high service utilizers were more likely to prefer service supports. Relevance of findings to current policy initiatives regarding financial incentives to families are presented.

### INTRODUCTION

The dual concerns regarding excalating health care costs and the quality of care afforded aged Americans, has placed a primary emphasis on developing cost-effective approaches to meet the long-term care needs of the frail elderly in the community.

An interesting development in these policy discussions over the past several years has been the expansion of the target population to include not only the elderly, but their families as well. Government officials on both the Federal and State level are now considering the development of public programs and policies to support families caring for aged relatives.

This relatively recent emphasis on family-oriented services and incentives is based upon the growing body of knowledge regarding the role familes play in providing care to the frail elderly. It has now been established that families are the predominant service and health care providers to the impaired elderly living in the community (Cantor, 1975; Hill, et al., 1970; Rosnow, 1967; Shanas, et al., 1968; Sussman, 1965; Townsend, 1965). Findings from a comprehensive study on cost comparisons of home care show that family and friends expend far more dollars than do agencies for maintaining elderly members at home and have been absorbing the largest portion of the cost compared to the expenditure of institutional dollars (U.S. General Accounting Office, 1977). Furthermore, the availability of a family support system consistently emerges as the primary factor in reducing the probability of institutionalization for the chronically ill aged person (Barney, 1977; Brody, 1966; Spark and Brody, 1970; Townsend, 1965; York, 1977).

Yet, the available evidence also indicates that relatives take on these responsibilities to the detriment of other responsibilities to self and family. They make extensive sacrifices in order to maintain their aged relatives in the community. Often these sacrifices can not be sustained indefinitely. Several studies have shown that the precipitator of institutional placement is more often exhaustion of family resources and excessive burden on family members than a change in the aged person's health status (Brody, 1966; Kraus, et al., 1976; Silverstone, 1978; Teresi, et al., 1978).

Furthermore, changing demographic trends promise to increase current pressures on families (Callahan, et al., 1980. Glick, 1979). Projections include an increase in the proportion of the most vulnerable segment of the elderly population, coupled with a decrease in family size. This is further complicated by an increase in the proportion of women who work and who are thus unavailable as full time caregivers to

the elderly. All these trends will limit the ability of families to maintain aged relatives without support, regardless of their desire to do so.

These pressures on families, combined with those on the public purse due to the rising costs of institutional care, have led to the recent concern with developing programs which will encourage and support families to care for aged relatives.

At the current time, actual efforts in this direction are minimal. Service supports to families have largely been offered through local, small-scale programs with time-limited funding.[1] Efforts at direct financial payments to families have been somewhat broader-based but still limited in focus. For example, the State of Maryland is currently operating a demonstration project offering cash grants to a limited number of families who care for an aged relative in their own home. New York State also has experience with cash grants through its home attendant program which has allowed the aged client to choose his/her own home attendant. The latter may be a family member who is subsequently reimbursed by the State through a dual-payee check. Only California has a statewide system, in operation since 1958, which provides relatively high levels of reimbursement for family-based attendant care. However, due to administrative problems and issues of accountability, there are currently efforts in the State legislature to overhaul this program (Callahan, et al., 1980)

Given these scattered efforts, the relative advantages of these different types of service and financial approaches remains more a subject of debate than of analysis at the current time. Furthermore, the eventual efficiency of these programs may depend on the extent to which they are, in fact, perceived as desirable by the families to whom they are targeted. Little data currently exists regarding the preferences of families actually caring for an aged relative.

Thus, the research reported in its paper address two major questions: which supports do families identify as most critical to sustain their caregiving efforts and do such preferences vary by the characteristics of the family caregiver and/or the caregiving situation?

## SUMMARY AND CONCLUSIONS

In summary, this research examined preferences for social and economic supports among a sample of 203 family members currently providing care for a frail aged relative. The study found that overwhelming majority preferred service programs, primarily homemaking and medicare care, to financial incentives. Furthermore, a significant minority refused to even consider economic supports in reference to their personal situation. The aged person's sex as well as current levels of service utilization were associated with a preference for service over economic supports.

These findings have direct relevance for upcoming policy decisions. On the most basic level, we must advocate that the preferences of potential recipients deserve to be taken into consideration in the formulation of public programs and policies. Evidence from both this study and that conducted by Sussman clearly indicates that those families who currently confront the reality of caring for an aged relative prefer service over economic incentives if they are faced with a choice.

Yet, most of the current debate, as well as initiatives regarding family support, have focused on providing financial incentives for family care. In attempting to understand why this is so, as well as why families appear to have contrary preferences, we must look at the assumptions underlying such proposals and the available evidencee relative to these same assumptions.

The basic underlying assumption behind programs which offer financial assistance to families is that the latter are faced with economic constraints which limit their ability to maintain their aged relative at home. Cash incentives are assumed to remove these barriers and induce families to provide home care to a frail relative. However, all available evidence contradicts these assumptions. The most recent studies have consistently found that of all types of stresses inherent in providing assistance, financial hardship is the least frequently reported by caregiving relatives (Cancer Care Inc., 1973; Cantor, 1980; Frankfather, et al, 1981; Simos, 1973). Findings from other aspects of our study are consistent with this conclusion. For exam-

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[1] An example of such a program is the Natural Supports Project of the Community Service Society of New York. This was a 3-year research demonstration program funded by the Administration on Aging to porvide respite and support services to families caring for an aged relative. Program operation was limited to New York City area and only 96 families were served during the life of the project. Although the evaluators concluded that "services were strong incentives for families to resist nursing home placement," program operation was terminated at the end of the funding period. (Frankfather, et al., 1981).

ple, only 3 percent of our sample identified financial assistance as the most critical help offered the aged relative; whereas 61 percent and 20 percent choose emotional and instrumental assistance, respectively. This is not to say that caregiving does not involve financial help nor entail economic costs to the family. Excluding the 19 spouses in our sample, 43 percent of the remaining caregivers helped their aged relative financially, and one-fourth of the total sample said that their family's financial situation had changed for the worse since having assumed the caregiving role. However, the strains associated with financial assistance do appear to be of lesser consequence when compared to the social and emotional impact of caregiving on the family. When asked what were the major problems they faced, only 4 percent spontaneously mentioned financial problems, whereas 64 percent mentioned at least one problem having an emotional component. Furthermore, only 3 percent identified financial assistance as the most difficult caregiving task. In summary, the available evidence indicates that the financial aspects of caregiving are not perceived as the most stressful by family members.

Furthermore, there is little empirical support for assuming that cash payments would induce an otherwise reluctant family to share its home with an aged relative (Prager, 1978). The majority of families respond voluntarily to the needs of their aged members to the best of their capabilities. As Sussman, (1977) concludes. "[a]t best, incentives facilitate the process and make it easier for the already committed and do little to change the minds of the refusers." The use of the word "incentives" itself, is therefore, a misnomer. The terminology implies that, by offering such programs, families will behave in ways which they would not have in their absence. The target population of a program under this heading would be the minority of families who reject their caregiving role and the success of such a program would be questionable.

Programs as described in this article act not so much as enticements as they do act as supports which maximize and, hopefully, prolong family efforts. From the families point of view, service, rather than financial supports best meet this goal.

While the general argument advanced in this paper has been in favor of expanded social and health care services, as a final note, it must be clearly stated that we do not question that financial support would be of benefit to many families and that most families would not reject the support if offered. If this were the best of all possible worlds, we would be advocating that both economic and service supports be made available, but this is not the situation. Current budget constraints only promise to get worse and choices are inevitable when resources are limited.

Mr. KILDEE. Thank you very much.

Ms. Burgen.

## STATEMENT OF ANN BURGEN

Ms. BURGEN. Mr. Chairman, I'm a nutrition program director in north-central Indiana and also president of the National Association of Nutrition Program Directors.

During the last month, we have been talking nationwide with a number of our members who not only deliver nutrition services but also do a number of other in-home services. Although there are not a lot of statistics available to us yet, we have been able to clearly see some patterns that are developing across the country.

I have heard many heart-rending stories the last month of people who have been dismissed quicker and sicker from the hospital. In the Homebound Nutrition Program alone, I have heard accounts of anywhere from a 4-percent increase to as high in Florida in one project of 65 percent increase in demand for the home-delivered meals. But across the country, it seems to us that around 30 to 35 percent is the more accurate figure.

There is also a big pressure building in our staff, because we are every day having to make decisions between service of two equally needy people, one who needs a long-term home-delivered meal; on the other hand, someone is getting dismissed from the hospital on an emergency basis for a short-term length of time in our program.

This is causing a great impact on our staff, because, even though we may have them for a shorter time, the level of service that they need is much deeper.

For example, if they are in need of a medical service, then the visiting nurse tells us that they have a greater need for a registered nurse as opposed to some of the other services that we have delivered before. If they request a home-delivered meal, they need not just one but two or three for a shorter period of time, but if they are not able to prepare one meal, they can't prepare two or three either.

We are also receiving requests now for specialized kinds of meals which we were not receiving before. Many people are now going home from cancer surgery who need special food supplements that we have never been able to provide before.

This has also been a real drain on many of our staffs, because every time somebody comes into the system we have to go through the whole assessment process, setting up the files in the delivery system, and even though the clients are on for a shorter time, what happens is that now we are serving three clients for every one we were serving before.

Our hospitals, on the other hand, when they are referring clients to us, are expecting that they receive priority in our service, and in order to meet this growing demand, what we are finding is that we are having to transfer more and more moneys from the congregate meals programs.

While none of our members would deny the need for the resources for the in-home care, we firmly believe that draining the congregate meal program is not the acceptable solution to this problem, because the benefits of maintaining health and wellness through sound nutrition and reduction in isolation have long been established.

I guess we refuse to accept the premise that our country is not able to fund the services that are needed for the client at whatever level they might need those services. Why have we accepted the premise that money is better spent on a client nearer death than one who just has not gotten that far along in the process yet?

We are of the opinion that if we reduce our congregate programs we will have many more frail, vulnerable elderly. We know that from just the experience of our congregate programs. We now have had people in our programs for 10 years who would have been in the nursing home many years ago were it not just for the congregate programs. I can't overestimate their importance.

We are also finding a number of other things that are happening in our communities. Number one is that the delivery of the in-home services are in flux. There appears to be a real fragmentation of service and less coordination among many of these new in-home service providers that are springing up.

The hospitals are doing a couple of things. In some areas, they are working very strongly with the area agency, the case management programs, the service providers locally. In other areas, they are establishing their own in-home care divisions or subsidiaries to receive private payment.

It appears that these new agencies are providing the services that they can get reimbursed for, and when they can't get reim-

bursed for a client, then they are referred to us, and we are receiving all of the referrals for the patients who cannot afford to pay. It's real sad, I think, that in our system, now, we are not client- or need-driven but funding-driven in determining some of these needs.

The client with the financial resources is often now being funneled into the private alternative, the hospital or the other in-home service provider, while the client with no resources is referred for community service. This isn't necessarily bad except when we do not have the funding to adequately provide those services or when those services are not available.

One of the problems we are also encountering is that, when someone is released from a hospital, most of our new service providers are in our urban areas, but we do not always have adequate services available in our small towns in our rural areas.

I have heard many stories of people who were released from a hospital in, say, the county seat of a county where the hospital is into a small, rural, isolated town with no services available of any kind and soon were back into the hospital in much worse condition than before.

There also seems to be a lot of confusion, partly because of the new marketing techniques that the hospitals are undertaking in order to keep their beds full, and we understand their concern, but a lot of our patients are very confused about the new systems, they are confused about the supplemental insurance, they are confused about who will take care of them: Will the insurance policies and the Medicare that they were relying upon now meet their needs when they need them?

The service providers are also encountering situations regularly that seem to indicate that discharge judgments no longer are based on a full picture of a client situation, and I included one example in my written testimony about an 87-year-old lady who had been discharged at home with no support at home for her.

But what we are finding many times is that, even if there is someone at home, it may be their daughter or their son who is also a senior citizen with other physical problems and totally unable to care for the patient.

Reducing the days of stay in the hospital may decrease the hospital costs, but the burden of care does not cease when a patient leaves the hospital, it merely shifts to someone else, and right now it's shifting to the community-based services.

We feel very strongly that the balanced philosophy that first caused the Older Americans Act legislation to be implemented was one that looked toward allowing the older person to live and function at their maximum capacity by offering alternative levels of service.

Today we seem to be focusing our service only on the frail. Therefore, the only way to receive a service is to be frail. We think that is wrong. We feel that we have to continue to reexamine the limitations of the DRG, the intensity of the illness, the support system that is out there and, by all means, if the community-based services have to pick up this gap, then we have to, in some way, see that they are funded at the level that we need.

Thank you.

[The prepared statement of Ann Burgen follows:]

PREPARED STATEMENT OF ANN BURGEN, PRESIDENT, NATIONAL ASSOCIATION OF NUTRITION AND AGING SERVICE PROGRAMS

Mr. Chairman and members of the Subcommittee on Human Resources, I am Ann Burgen, a Nutrition Project Director of an eight-county Nutrition Program in North Central Indiana. I am also the President of the National Association of Nutrition and Aging Services Programs. I want to thank you, on behalf of the Association, for your invitation to testify before your committee.

The impact of the Diagnostic Related Groupings (DRG's) on Older American Act Title III Programs has been immediate and dramatic. The full measure of that impact, however, is still evolving as communities across the country implement DRG planning and develop strategies to deal with the consequences of DRG's within their local boundaries. NANASP has surveyed representative members who provide both nutritional services and other in-home direct services in states from each section of our country. We can, at this point, see patterns emerging and offer some beginning analysis of what DRG's mean to our programs and to the clients whom we serve. We will develop this testimony to deal not only with the direct impact on our Title III programs but also with the impact on community-based service delivery systems for elders that Title III programs are a part of, and the impact we are observing on our clients and their families.

With the advent of DRG's, hospitals are discharging elderly patients "quicker and sicker". The direct impact of this method of determining reimbursement for care has led to an increase in demand for services provided under Title III of the Older Americans Act. Statistics from home-delivered meal programs alone are reporting increases from 4% to 65%. The average increase in meals served in the home by our programs appears to be near 30%.

There is pressure building with direct service programs and program staff. This pressure stems from the increasing requests for service and the intensity required for adequate client care. Staffs find themselves faced daily with determining who should receive services. Choices between clients needing long-term service vs. needs for emergency service for newly discharged patient are difficult. When service is required to allow for the discharge of a patient, waiting lists are not reasonable alternatives. In addition, the reduction in recuperative time in the hospital means that clients tend to be more frail upon discharge and require multiple services with greater depth in service. For example, if home-health services are provided, more skilled nursing service is required; if home-delivered meals are requested, more than one meal is necessary to sustain the client and more modified diets and special prescribed dietary requests are made. A study published in the July 4 *New England Journal of Medicine* and summarized in *Older American Reports* concludes that "a reliable measure of severity of illness is needed" for the prospective payment system to be equitable. While this report pertains directly to hospital payment, implications are apparent that a rigid system of reimbursement means that individual client condition is not the determining factor in establishing release dates from hospital care.

Because we are witnessing a trend to more clients on a short-time basis, we are finding an additional drain on administrative resources. Each time a client enters the system, assessments must be made, client data gathered, files set up and service delivery established. And even though the clients are on our programs for a shorter time, we are serving three (3) clients for every one (1) client we were serving before. This requires staff time and takes dollars from already strained budgets.

Hospitals that are relying on Title III services to provide needed care for their discharged patients assume that those patients will receive priority in service delivery. Limitations on service availability create crisis situations.

To meet this growing demand for in-home services, more monies are being shifted from the congregate meal programs. While none of our members would deny the need for resources for in-home care, we firmly believe that draining the congregate meal program is not an acceptable solution to this problem. The benefits of maintaining health and wellness through sound nutrition and reduction in isolation have long been established. The congregate program also offers an alternative level of support to those clients progressing toward independence in their recuperative process and, in some communities, an increase in congregate service parallels the increase in home-delivered meals. The importance of the congregate meals program should not be lost as we struggle with the issues of long-term care.

In our discussions of DRG's with service providers throughout the country it became obvious that community systems for the delivery of in-home services were in flux. In general, there appears to be increasing fragmentation of service and less coordination as major service suppliers try to adapt to the changes linked with DRG's.

Hospitals that are aligning themselves with local agencies for services upon patient discharge expect to have access to those services and are not familiar with the funding limitations that are a part of our reality. In a few cases, hospitals are now competing for Title IIIB dollars. Some hospitals are establishing in-home care divisions or subsidiaries to receive private payment for services. There appears to be a move by hospitals and other private companies toward providing reimbursable services in the home but no move toward "gap filling" to insure an acceptable level of care to all.

In general, the system is no longer "client (or need) driven" but "funding driven". It appears that hospitals have not reduced or absorbed unacceptable costs associated with hospitals stays, but rather just release patients earlier regardless of their condition. Once released, the client with financial resources is often channeled to a private alternative for in-home service, while the client with no resources is referred for community service. This is not inherently bad except when there are not adequate community services or when those services (such as Older Americans Act Services) rely heavily on client donations to maintain programs. At a time when we are serving a more frail, vulnerable, financially poorer client, we are being instructed by Federal initiatives to ask the clients to donate more for the services we provide.

Another concern we have is that private alternatives for in-home care are often clustered into the urban areas while rural clients are left with few choices. Social services professionals from various networks are finding it difficult to understand what is happening with service delivery and expectations of support are often different than what is actually available.

In order for hospitals to survive, it seems that they are trying to maximize revenues available to them under the DRG system. They are undertaking "marketing efforts" to insure a steady flow of older patients into their care. Some of these marketing efforts mislead the older clients into believing that if they become a member of the hospital's "Golden Card" group, for example, this will insure them extended care beyond the DRG limitations should it become necessary.

Of greatest concern is the impact of DRG's on elderly clients who are finding themselves in the midst of this changing health care scene. There is a real loss of confidence that the "system" will care for them and an increasing anxiety over any deterioration in their health that might require hospital treatment. Combined with this general anxiety is confusion over what has happened and the new complexity of the situation. Many older citizens feel cheated by supplemental insurance which they felt would safeguard them and are unsure how to prepare for the eventuality of hospitalization and/or extended care.

Service providers are encountering situations regularly that seem to indicate that discharge judgements no longer are based on a full picture of a clients situation. (For example, in the Southwest, an 87 year old woman who had undergone extensive heart surgery in the past year was treated on an out-patient basis for a hernia, as called for in DRG guidelines. The community service worker found her to be emotionally unprepared to deal with her condition without hospital support.)

Deaths that occur because of premature hospital discharge and/or lack of in-home support services do not show up statistically as failures of our medical system. Tracking progress of elderly discharged patients will be essential in determining the real impact of DRG's in the most fundamental test.

Reducing days of stay in the hospital may decrease hospital costs, but the burden of care does not cease when a patient leaves the hospital wing—it merely shifts. The responsibility to insure adequate health care for Older Americans and to reassure these citizens of our concern is more evident now than ever before.

If the DRG concept is to be successful, not only from an economic perspective but a human perspective, the formula must be flexible and take into consideration the severity of the illness within the dignostic category, the availability of family, community and/or private in-home support upon discharge, and the emotional capability of the patient to deal with the responsibility for self-directed care.

If Older American Act programs continue to be an essential part of the community service picture, we must have the resources to hold up our part of the bargain in providing long time care. We should not be placed in a position of either altering the scope of our programs (reducing from five day delivery to four, or two meals daily to one) or removing clients who need long-term care to make room for clients with emergency needs. The balanced philosophy that has guided the Older Americans Act legislation toward a service structure that encourages elderly clients to function at their maximum capacity by offering alternative levels of service, must be continued.

A comprehensive, client-centered system for health care is a goal that we must pursue. Ability to pay should not be the only assurance of quality medical or in-house care. Profit can not be the only factor that leads to adequate levels and ranges of services.

Older American Act programs are in a unique position to observe and report the results of changes in our health-care system as they affect elders. Our base of information is our daily contact with the people who are most impacted by these systems and our program data. We appreciate this opportunity to share our observations and conclusions with you. Thank you.

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Mr. KILDEE. Thank you very much.

Mr. Reiter.

Mr. REITER. I'm Dick Reiter. I'm from a town in Iowa—Dubuque, IA. I'm a hospital operations administrator, and we've been watching with a great amount of concern and interest the Medicare System, the health care system in this country.

I've been in the service industry for 20-some years. I've watched Medicare over the 20 years. Congress, in its wisdom, when it developed this program, I think, had a little different idea about what was going to happen with older Americans. I don't believe they dreamed in their wildest, wildest dreams that there would be this much utilization of care or that there would be this many older people that would live to the ages that we see today.

Through these 20 years, I've seen the program 3 years after its inception run out of funds, and each year a continuing ratcheting of the system. Every year we found continued problems with it. So I guess I'm a little bit surprised that we haven't learned through all of this experience, but we do keep coming up with new solutions, and I guess the DRGs is one of the latest solutions.

The phenomena you have heard of from these other panelists are the phenomena that we are experiencing, and we see much, much sicker patients coming to the hospitals. There is no secret about that. We have watched our case mix index go up and up for Medicare patients. There are more things wrong with them.

If you think that people are getting discharged from hospitals in conditions different than they used to be before the DRG system, you should see what it's like to get into a hospital with the professional review organization criteria that we have. It's astoundingly difficult.

So we see the patients being discharged earlier, we see continued numbers of elderly people over 65 using services more and more.

We are human beings, and we react just like the system expects us to react. When you develop incentive systems like the DRG, you can pretty much predict what is going to happen with the care continuum when you pay people to offer services and let them keep profits, excess revenues over expenses, if they operate efficiently.

We tried as a hospital system—the Sisters of Mercy—to respond in what we think is an appropriate fashion, developing alternate services, and we have also tried to work very closely with our community agencies, because we know that's where these people are going after they leave us so early.

We have got skilled nursing units that we now have in our town. We have developed a respite care program, a home health care program; we have done all the vertical integration that you see going on in the newspapers.

We have no problem with demand for the services. The demand is overwhelming—plenty of demand for it. The old problem, of course, again, is still the funding for it. Everybody wants something. They want more of what they had before, but they want to pay less for it, or they have less to pay for it with.

Our concern is really deepening about our ability to serve an aging population. As a health care system, we are pledged to providing care for the elderly, and we are pledged to providing care for the poor, and we are worrying about these people slipping between the cracks. The poor—that designation is getting to be a lot wider band than it used to be.

As you know, the elderly population is growing at a phenomenal rate—people over 65. We know that during the next 40 years that population segment is going to more than double, and it's growing the fastest, and it contributes the most to the use of health care.

Just 2 years ago our experience with people over 65 was 11 percent of our population, and they were responsible for over 42 percent of the hospital in-patient charges. We see this population segment continuing to grow and continuing to develop problems.

We know, and I think you know, that we must have a continuum of care available in the system. It just can't be at one end or the end that's paid the most for or the best for. We want to include acute care in that continuum, long-term care, and community care. Unfortunately, the DRG system makes very little compromise for age.

All sorts of data exist that will show and demonstrate that cost increases as a function of age for those over 70. Two-thirds of the Medicare population is over 70. There are lots and lots of complications with this segment—these people—very, very ill; many, many things going wrong. It's absolutely no secret that patients are not being admitted to hospitals as easily as they used to be.

You will find a lot of helpless and frustrated people at our facility going through the motions of getting an elderly person admitted to a hospital. The Iowa Foundation for Medicare has very, very rigid requirements for admission to a hospital. I contend on a daily basis with very, very angry physicians.

Fortunately or unfortunately, hospitals seem to be the hub of everyone's blame lately. The patient doesn't understand why they can't get in. They don't understand why they can't stay. The doctor is mad because he can't get the patient in. Someone leaves this at

our doorstep and says, "Here, you explain it to the patient; you tell them."

We have added three social workers to our already burdened social work staff—medical social workers with MSW's. We know the incentive under the DRG is toward reduction of service, but we want to beware that the shift to earlier discharge does not create the need for so much post-hospital care that we are not committed to providing.

Again, we seem to be driven by the finance of this system. Adequate financing for post-hospital care has already been, I think, well spoken to. It's one way of showing commitment. I guess it boils down to a value system for people that you have spoken of, Mr. Chairman.

I don't have any doubts that our system will respond to whatever incentive is developed, whatever system is developed, or non-system, if you will. I worry that the tinkering will continue, and as we tinker with the system, the health of our Nation might be in jeopardy.

Good secondary support systems are necessary. They need to be enhanced through proper funding, and I know it isn't popular to ask for money now, but I guess it's a priority situation.

We are talking about limited resources. It just depends where you put your values. The time to work with patients for discharge once they come to us in a hospital is very, very precious now. There isn't that time. There is essentially no recuperative period for patients.

When the elderly, especially the frail elderly, go home, a lot of things must happen. Many go home, but they are not able to care for themselves. I've had discussions with our area agency, and we are working on continuous meetings with them on a regular basis.

We send people home. However, we find many times through our research that there is nobody there to take care of them, or the person at home is almost as sick as they are.

We'd like to see an increase of funding for services for some of the things that I guess we take for granted. Until I got into actually talking with some of the agencies, I had no idea of the tremendous need for these programs. When people can't cook their own meals, they have to have somebody there. If you have home-delivered meals, it's a tremendous aid.

One of the phenomena we have also experienced is that with a pre-DRG program patients could go home and utilize some of the services like the home-delivered program, but it maybe was for a week or two, and they were better and able to make their own meals. Now we find that period much, much longer. They are much, much more sick when they leave. They need the help for longer periods of time.

I won't go through the continuum of post-hospital care programs that are needed. I think you will find those things well documented in some of the testimonies that you have.

With this problem that I have somewhat outlined for you, the criteria for the elderly being so rigid that they can't get into the hospital, these tight policies that we have not only for us but for the agency programs, I find, after talking with the agency people they are doing daily prioritizing. They are robbing Peter to pay

Paul. They find that they have to make decisions about whether to spend some money on home-delivered programs or on chore services and other types of support services. They have done a fine job of this, but that only lasts so long and goes so far. These people burn out also.

The elderly are just showing too great a need for the funds that are available. We still have elderly that are falling between the cracks. They are too sick to stay at home, to care for themselves, but don't meet criteria that are so rigid for admittance to a hospital.

We have talked about, for as long as I can recall in health care circles, the need for preventative medicine. I don't know how we ever will get preventative care for our people when we are always just putting bandaids on severe problems. These people will not get better with systems that only reward for acute episodes of illness.

I don't think the time is available for us to spend much of it on blaming someone for it, whether it be the hospital, home agencies, or what. We have been careful to make sure we understand our mission as a provider. We do spend a good deal of time making sure that no one is denied care because of their economic situation.

I can show you financial data to show you how we only got 22 percent of our reimbursement on outlier cases under DRG. I can show you the fine system we have in a home care program. We have a sliding scale fee for people. They pay what they are able to pay.

But I don't think you want to hear all of the findings we are doing either. I think you want to find some way of attacking this identified problem, and I don't have the answer for you, other than to reevaluate how we place our values. Where do we want to spend it?

Any system you come up with, I can guarantee you, will develop a way to utilize the dollars that are there. Better planning and close cooperation among all kinds of providers is absolutely necessary.

I think that's about all I have to say. Thank you.

Mr. KILDEE. Thank you, Mr. Reiter. You have given us another insight into this problem.

Let me ask you this. I'll start with you, Mr. Reiter, but others may feel free to join in response, if you wish.

The DRG does not really mandate a number of days for hospitalization—does it? but merely gives the average that would be looked upon for that particular diagnosis.

Mr. REITER. That is correct.

Mr. KILDEE. So it doesn't mandate, say, 12 days, but it would say that the average is thus, and then the hospital would have discretion either side of that average.

Mr. REITER. It will certainly identify for you the kinds of motivations of providers in a system like that.

Mr. KILDEE. Say we have a 12-day stay average for a certain diagnostic-related group and the hospital is able to get the person out in 8 days, there is incentive then for the hospital to get them out earlier—right?

Mr. REITER. Absolutely, yes.

Mr. KILDEE. A disincentive to keep them longer.

Mr. REITER. Right. The idea there is to understand that hospital care traditionally is the most costly type of care. So the incentive of the people with the wisdom that developed the DRG program was, I guess, appropriate in that you want to remove people from the hospital where the high cost is into a lower cost type of care.

Mr. KILDEE. Human nature being what it is, with a fiscal crunch and with hospitals really competing—that's a very common phenomenon now—isn't it? there is going to be a temptation—is there not? to try to get the person out early for fiscal reasons.

Mr. REITER. Yes, there is a temptation for that. It depends upon what type of philosophy drives your organization.

Hospitals—and I have to admit my bias; you can appreciate that—were caught between the crunch of competition and regulation. I could bore you with some details of a program we tried unsuccessfully to launch for 3 years in our town, a program aimed at providing congregate living for the elderly, ways for them to live with supervision, step-down levels of care, apartments, handicapped living. Couldn't get it for 3 years through the certificate of need approval. Took it to the Supreme Court; failed all the way. Finally gave up and have a building that we purchased. We reduced the number of beds in the community by 150, and the building sits there losing a half a million dollars a year.

Those are sad stories, but you do what you have to do within the system.

Mr. KILDEE. I think what we worry about is, that a hospital will discharge a patient for a fiscal reason rather than a medical reason. That is a conflict, and that's a real possibility.

Mr. REITER. It's a conflict; it's a real conflict.

We have a quality assessment program at our facility. We even have a quality assessment program committee composed of board members who, on a monthly basis, look at a wide range of data indicating the types of patient we have had. If we are not adhering to the quality criteria that we establish on a monthly basis, each of our departments comes before another committee in our hospital to testify and attest to what kinds of changes, if any, there are in the qualities of those departments.

We have identified those quality characteristics, and I applaud our personnel for those things. None of them are based on fiscal factors. They are all based on past kinds of quality assessments that we had long before any DRG system. Our entire program was based on that.

As I look at our multi-hospital system, I also see evidences of, I think, Christian concern for those that need help and those that need care. The gentleman from Michigan is probably aware of Samaritan Hospital, inner city of Detroit. It takes a real mission to keep a hospital like that. There is nobody out there looking for those kinds of hospitals, believe me. They lose millions of dollars a year. But someone has to care for the poor.

Mr. KILDEE. Humana is not going to buy that type of hospital.

Mr. REITER. I don't think so. But I shouldn't speak for them. They might.

Mr. KILDEE. How often does this happen? Where a patient is told that Federal law requires that we discharge you tomorrow. I know that happens. How often does that happen? I get calls, and they

say, "That law that you passed, they just told me that the Federal law requires that my mother be discharged tomorrow." How often does that happen?

Mr. REITER. I don't believe I can tell you how often it happens. The process that we use—and I think it's dictated by law—is that a letter is given to the patient, and it indicates not that they are going to be discharged now, but it indicates that their Medicare coverage for their period of illness as of this date ceases. They may stay in the hospital if they want, and that will be the hospital's responsibility. That's how we handle it.

It's our responsibility to tell them that Medicare coverage ceases and that we will look for and will work with their family on finding a solution to their needs now that they are at that stage.

Mr. KILDEE. Yes?

Mr. DOLSEN. I guess that's one thing that has bothered us. We have talked to discharge planners about that, because Medicare coverage does not cease. It's merely an average.

What has happened is that the average has become the cap. In essence, one person gets up to the average number of days that that DRG would ordinarily permit in the hospital, and the hospital tends to see that as the cap, and the person becomes a liability for the hospital, not necessarily that the Medicare has ceased its coverage.

Mr. KILDEE. I think that's the core of the question. I think the impression given to the patient is that Medicare coverage stops. Does it stop?

Mr. REITER. I might add that in the State of Iowa we have a little different situation. We have the Iowa Foundation for Medical Care who also limits by the number of days and by the kinds of cases that you have in the hospital how long you will stay. It's a quality review. It's a utilization review which has nothing to do, at least for the Iowa Foundation of Medical care, with cost. Indirectly it does, because the Government contracts with them to do the utilization review, but they are the body in Iowa who determines how long someone will stay. There is a definite number of days you can stay in for DRG number 25.

Mr. KILDEE. OK. Let me ask this question. Suppose your DRG would say you have—let's take 10 days, and you're discharged after 12 days. Who pays?

Mr. REITER. That's a 2-day outlier to us. If it goes more than 7 days, it would become eligible to go through a red-taped term of events to get payment for the outlying days. We have what we call day outliers and cost outliers.

Mr. KILDEE. All right. Let's just say the 2 days you might appeal. Who would be liable for payment—Medicare, the hospital, or the patient?

Mr. REITER. The hospital, in Iowa.

Mr. KILDEE. Not the patient?

Mr. REITER. That is correct. We cannot bill them for it, and will not—would not.

Mr. KILDEE. What's the case in Michigan?

Mr. DOLSEN. Very similar. The hospital would be responsible. We don't have the review system in Michigan that they do in Iowa.

I'd like to commend Mr. Reiter for his sensitivity toward the problem. I appreciate that.

Mr. KILDEE. I think the committee appreciates that also.

Mr. DOLSEN. One of the things I find in Michigan is that three people of identical age with an identical illness could come to the admitting room of a hospital; one may go in and stay for 2 weeks; one may go in under the DRG system for 3 days and be released; and one may be denied care at all.

Mr. Reiter made reference to the Samaritan Hospital. I think one of the tragedies of it is that the Samaritan Hospitals of the world are picking up those that are being turned away by other hospitals, and that's the tragedy.

I think we have tended to underestimate the competitive structure and the market system and what that has done to hospitals. I think I infer from Mr. Reiter's remarks that often hospitals do things that they would not before the DRGs have done simply because they feel driven by the market system. They move people out that they wouldn't ordinarily move out.

I guess he is probably right in terms of, we're probably not to the point where we should start finding villains in all of this, but the problem is certainly there, and those people are released early. They are released and, unfortunately, are often denied admission.

The whole force in order to make the average of the DRG the cap is really there. If that doesn't happen, another hospital will do that. Hospitals will start to hew toward that average in order to maximize their profits and survive, and that's what is happening out there. It's getting quite vicious.

Mr. KILDEE. Let's take this case then. Suppose the DRG calls for 10 days. A certain patient is discharged in 8 days. The hospital makes some gain there—right?

Mr. REITER. That's correct.

Mr. KILDEE. So another patient is discharged in 12 days. Wouldn't that tend to balance out then?

Mr. REITER. Yes, it would. If you look at the country in aggregate, the experience for the hospitals has been what I would call good under the system. But you're only talking about one parameter, and that's payment. You have to look at some other characteristics. I hate to think about it, but you had better start looking at the health status of the population rather than at the pocketbook. One is a function of the other, but that will be with us for a long time until some of these judgments about how we are going to spend those dollars change.

We have had good experience in getting trained for the decrease of utilization in hospitals. We had HMO's in our community 4 or 5 years before the DRG's came along. We are experienced at having our utilization drop from 1,000 hospital days per 1,000 population down to 400.

So the shock was nothing for us like it was for many other hospitals in this country when they saw the utilization drop. We have had an opportunity to get some good management techniques developed at the hospital so that we could sustain ourselves through programs like this. Many, many hospitals were not as fortunate, didn't think as far in advance, and get sort of whip-sawed in this competition program. Competition at any price is a problem.

Our chief executive officers in our programs are hospitals. It's kind of distasteful to us to see some of the things that are going on in the industry. We think in terms of service, not product line.

It's kind of ironic, however, that the very people that are quite concerned about the cost, the people that pay for it—the large payers—are not at all shy about coming to a provider and saying, "Hey, I think next year I'd like to pay you differently." It's a really frustrating position for a health care provider to be in. You have to change pretty quickly.

Mr. KILDEE. Let me follow through with one more question on that. When that person is told after the 10th day Medicare is not going to pay, the impression that patient will have then is that if they stay there, they are going to pay—right? and that's not really the case.

Mr. REITER. No, it isn't the case. The amount of understanding by the patient varies, and the amount of effort made by a provider to make sure that the patient understands will vary across the board.

We do our best. We have social workers; we have a pastoral care department; we have a patient advocate in our hospital. It's their mission and it's their responsibility to make sure that these people are the least frightened as possible.

Believe me, there is no one that wants to pay their bill any more vociferously—is any more dedicated to payment of their bill than our elderly. You wouldn't see this kind of behavior anywhere, from any population of people. We have people that actually spend hours before they leave the hospital; they want to make sure their bill is correct. They don't understand some of these regulations. It's difficult to understand unless you have been in the situation yourself.

Mr. KILDEE. I think you and your hospital have a real sensitivity. I don't think that's the case with all hospitals. I am convinced that some hospitals take advantage of the patient's lack of knowledge. When they say, "The Federal Government says you must leave the hospital tomorrow," that's a lie. Some hospitals are lying to patients, not just occasionally, but sometimes systematically.

Mr. REITER. I suppose that's possible. I don't know. It's a generalization, and we don't do that type of copping out. It's important to us. It's in our mission. Everybody is always going to tell you that, you know.

Mr. KILDEE. I recognize that. You are the good guys here. [Laughter.]

No. You are. I think I'm a good judge of character. I think you have a certain sensitivity.

But I've heard that expression. They say, "The Federal Government says you must leave tomorrow." That is the business office of the hospital taking charge over the medical office of the hospital, to make fiscal decisions over medical decisions.

I think there are some defects in the DRG system, but I think much of the defects also are in the administration of the DRG system, and, as you point out, human nature being what it is, you kind of lead people toward decisions like that.

Mr. REITER. Maybe you would want to lead some of your colleagues toward considering the severity of illness of people.

This gentleman indicates that there is a broad range of differences between two people that might be 60 years of age—or three people. The severity of illness is just off the wall with patients. You don't have an appreciation for this until you actually see the thousands of patients and the different kinds of complications that they have.

Some work has been done, I believe, at Johns Hopkins on a DRG system based on severity of illness. It looks good. Of course the more accurate we get, the more time it takes. But if you are looking for alternatives, that's one area that may help.

Mr. KILDEE. Is there a difference in the DRG suggested length of stay or average length of stay for, say, a broken hip for someone who is 60 and a broken hip for someone who is 85?

Mr. REITER. Is there a difference——

Mr. KILDEE. A difference of the average length of stay, but under the DRG system.

Mr. REITER. Oh, I'm sure. There could be complications that would take us all afternoon to talk about, not only medical but social.

Mr. KILDEE. OK. What I'm trying to ask is, how much flexibility is there within the DRG as to average length of stay within a certain diagnostic-related group? A broken hip being a case in point. How much range is there?

Mr. REITER. The range is very narrow. There is a waiting that you get, and you can move into different numbers based on complications. But they are so narrow that it doesn't take into consideration what is important.

Mr. KILDEE. So you think there is not enough adequate flexibility. Say age alone—is age alone a factor, say, between 60 and 85, for a broken hip?

Mr. REITER. They give you one consideration for age, and that is if they are over 70, period.

Mr. KILDEE. There is one—over 70. Do you think that is inadequate?

Mr. REITER. Oh, yes.

Mr. KILDEE. That there should be flexibility of tucking in other considerations?

Mr. REITER. Seventy is just a number—only a number.

Mr. KILDEE. Some people can be quite robust yet at 70 and other people quite frail—right?

Mr. REITER. Yes.

Mr. KILDEE. Would you say the DRG system has too much rigidity in general?

Mr. REITER. Life in terms of health is not that simple to determine and cut it up into 467 items. It just isn't that simple. We are complex people and have a lot of funny things going on with us, not all the time exhibited by just our physical condition either.

Mr. KILDEE. Thank you, Mr. Reiter. You have been really very helpful to the committee, and I guess we have asked some tough questions. We really appreciate your testimony and appreciate your own sensitivity very, very much.

Let me ask one more question. How significant is the problem of, say, inadequate numbers of nursing home beds when people being discharged from a hospital are moved into a nursing home and, as

they come in, other people who should be able to stay there are being excluded? As some come in the front door, you are putting people out the back door because of intensity of need. How much of a problem is that?

Mr. DOLSEN. That has become quite an issue in Michigan. Michigan has a certificate of needs system, and nursing home beds have been capped, and they haven't been built.

But it's interesting that the nursing home industry in Michigan has said that the reason they have to have more nursing homes is that there are no alternatives for community-based, long-term care in the community. At the same time, while it is an excuse, for example, to justify the building of nursing home beds, the nursing home industry does not advocate for more inhome care.

I find generally that, even though nursing homes are taking people who are sicker, for the most part, if there were an adequate home care system developed—community-based system developed, the pressure would be relieved considerably on nursing homes.

Looking at public policy both at the Federal and the State level, there must be a decision whether we are going to go toward the institutional long-term care system or the inhome-care system. Heretofore, I think the emphasis has been on the institutional system. I really don't have that great a sympathy for the increase in nursing home beds.

Mr. KILDEE. OK. With the lack of adequate inhome services now, is there a problem, though, of people coming in, say, the front door and other people being pushed out the back door without adequate inhome services to take care of those being forced out?

Mr. DOLSEN. We don't find people are being forced out. We find the list at the front end growing longer.

Mr. KILDEE. Okay.

Mr. DOLSEN. But I think it's important to point out that people in nursing homes, with the exception of those with dementia, who are perhaps 50 percent of the people in nursing homes, are no different from people who receive inhome care in terms of their functional disabilities for the large part.

The things that drive people to nursing homes are generally dementia and incontinence; those are the two big ones. Once incontinence, for example, and other functional disabilities can be handled and managed in the home, there really is not much of a difference between the nursing home population and inhome. It's the lack of that inhome that causes the problem.

Mr. KILDEE. I guess I'm raising this point because of my own mother. When she left the hospital, she went to a nursing home. Then, because in our community they had some inhome services, and only because of that—was she able to leave the nursing home and get back home where she lives alone. She had some therapy, a nurse coming in, and the Meals on Wheels.

So it's important, if we are going to move them through that nursing home situation, that there be those inhome services.

Mr. DOLSEN. Absolutely.

Ms. BURGEN. Could I respond?

Mr. KILDEE. Yes.

Ms. BURGEN. Another thing that is happening in the area that I live in is that the hospitals have had lots of empty beds. We also

have an overabundance of nursing home beds in our area. But the hospitals are changing their floors that they have closed for regular hospital patients and are converting them to rehabilitative types of services that are not going to be in direct competition with the nursing homes. I think that's something we need to watch also.

Mr. KILDEE. They can draw from the same Federal dollars then?

Ms. BURGEN. That's correct.

I had some instances given to me as examples, when I was doing some research, from the nursing homes, who are really concerned that they can stay open also, because of what is happening in the hospitals, and also that some of the hospitals doing inhome services are taking their patients directly from the hospital to their inhome services without going through any of the coordinated delivery systems or case management kinds of systems. They are getting services that they get funded for, but we don't know what other services they might need, because there is nobody doing that kind of comprehensive management study on them.

Mr. KILDEE. A hospital will keep a closed system for various stages of need.

Ms. BURGEN. A closed system. And that's what we're finding, particularly when the DRG's have been in over a longer period of time.

Mr. KILDEE. Thank you very much. This panel has been very helpful. I really appreciate the testimony of all of you.

You are testifying here on Capitol Hill, not Mount Sinai. We don't have all wisdom here. We appreciate your input, and hopefully we will make some better decisions here. Thanks a lot.

Ms. BURGEN. Thank you.

Mr. DOLSEN. Thank you very much.

Mr. REITER. Thank you.

Mr. KILDEE. Our next witness is Mrs. Vita Ostrander, president of the American Association of Retired Persons.

## STATEMENT OF VITA OSTRANDER, PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Mrs. OSTRANDER. I'm especially pleased, having heard all of the testimony this morning, at all of the areas of the questions you have raised, because it corroborates a good bit of what AARP will be saying.

We really want to thank you for this opportunity to share our views on the Medicare DRG prospective payment system and its effects on the Older Americans Act programs.

As you know, we have a full statement on record. So this will be just a summary statement.

AARP is committed both to high-quality care and to containment of health care costs. We supported the introduction of the DRG system in the belief that it had the potential to help achieve both aims. Instead, under DRG's, as you have heard this morning, Medicare patients are being released quicker and sicker and often without proper followup care. This unfortunate situation results from a set of incentives that lead hospitals to skimp on services, thereby jeopardizing older Americans' health and to shift a larger portion

of the cost of services to the Medicare beneficiaries and their families.

Also, the pattern of releasing many older Americans from hospitals before they are completely recovered is creating unprecedented pressures on families and on the existing service network.

Many communities lack an adequate supply of skilled nursing beds or trained inhome service personnel to meet the aftercare needs of older persons released from the hospitals under those circumstances.

Evidence of harm to patients has been mounting, tracked by Congress and concerned organizations. AARP is also trying to evaluate the scope and breadth of the problems affecting patient care under DRG's. The association has received over 400 letters and numerous telephone calls from Medicare beneficiaries, their children, nurses, and social workers, complaining about poor care and premature discharge under DRG's.

What we are seeing is a great deal of anxiety and frustration on the part of Medicare beneficiaries and their families under the DRG prospective payment system. I can tell you from personal experience with the calls I am getting from friends, such as:

> What will I do with my 85-year-old mother who had a stroke, still has a catheter? The discharge planner told me her days in the hospital are over. She has given me a list of Medicare-certified skilled nursing facilities. No bed is available. I must take that mother home. I am not equipped to handle a patient with a catheter.

I have had to refer her back to the discharge planner in order to determine where she will plug into the system. This is a case of limited resources not eligible for the Medicaid services. Therefore, it is creating an additional burden both on the beneficiary and the family. The daughter works. So it means a loss of income for that family.

This is only one of many instances. As I travel the country, I have had State directors for aging, such as the director from the State of Kansas, tell me in no uncertain terms that she is receiving calls from beneficiaries, from families, unable to deal with the consequences of early discharges.

I have had contacts with Visiting Nurse Association directors who have made it clear to me that the patients are coming out sicker. It is straining their capabilities of providing services. So it is coming from many areas, from many sources, both those who are advocates for the elderly and those providing services to the elderly.

We have interviewed long-term care ombudsmen, area agency on aging directors, and State unit on aging directors from around the country to obtain their observations. There is no question but that demand is increasing rapidly for the inhome and supportive services offered under title III (b) and (c) of the Older Americans Act.

This increasing demand comes not only from the growing population of frail, very elderly persons, the traditional recipients of home-delivered meals and other services for the homebound, but also from patients and their families reaching out for assistance.

Unfortunately, traditional Older Americans Act services do not always match the need. Even where appropriate services are available, the turnaround time required for arranging them is often prohibitive. They must stand in line to be available.

While the Older Americans Act programs cannot be expected to resolve single-handedly the complex problems emerging from the movement to the DRG system, a number of important actions can be taken that will help to ease the transition and protect vulnerable older persons.

AARP's discussions with aging network professionals as well as with affected older persons have helped to shape the following recommendations:

(a) Provide accurate information to older persons about the DRG and their rights under it. I think you, yourself, this morning raised some questions. That must be strong—their rights under it.

(b) Promote stronger linkages between community supportive services and hospital discharge planners; strengthen case management at advocacy functions.

(c) Direct more Older Americans Act resources to the frail and homebound.

(d) Strengthen research on long-term care and training for long-term care professionals.

(e) Through the long-term care ombudsman program—and may I say that this program is invaluable in this area—continue to monitor the DRG system. Investigate and research complaints, and actively assess the DRG's impact on long-term care.

(f) Adequate funding must be provided for inhome services, home-delivered meals, research, training, and demonstration.

In conclusion, Mr. Chairman, AARP has always believed that it is possible both to contain health care costs and to provide high-quality health care. We continue in those beliefs. We are deeply concerned, however, that there has not been an adequate effort by HCFA to properly monitor and administer the system so as to avoid erosion in the quality of care for older Americans, and this must change.

In the meantime, vulnerable older Americans, their families, and providers of a broad range of skilled and supportive services will continue to feel the pressures created by these policies. Such pressures, we should note, only exacerbate the effects of our too slow collective response to radically and rapidly change national demographics. That is why the role of this subcommittee and of the Older Americans Act programs is so important.

We commend the members of the subcommittee for calling attention to the problems associated with DRG's, the potential for a constructive response through the Older Americans Act, and the need to plan fully and carefully for larger changes related to this demographic shift in the years ahead. We at AARP stand ready to work with you in anticipating and preparing for those changes.

Thank you.

[The prepared statement of Vita Ostrander follows:]

PREPARED STATEMENT OF VITA OSTRANDER ON BEHALF OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Good morning, Mr. Chairman, my name is Vita Ostrander and I am President of the American Association of Retired Persons. On behalf of the 19 million members of the AARP, I want to thank you for this opportunity to share the Association's views on the Medicare DRG prospective payment system and its effects on Older Americans Act (OAA) programs. The Medicare DRG system is 21 months old now and all non-exempt hospitals participating in Medicare have begun the phase-in to-

wards national DRG rates. Thus it is a good time to step back, take a look at what is happening to patients, their families, and supportive services in the community under DRGs, and make necessary adjustments to the system.

The critical points I intend to make today are as follows:

(1) The DRG system creates the economic incentive to skimp on quality care. Older Americans are being hurt by the Health Care Financing Administration's failure both to monitor adequately and to correct this problem. The result is that patients are being released "quicker and sicker" and often without proper follow-up care.

(2) Many communities across the nation—rural and urban—lack an adequate supply of skilled nursing beds or trained in-home service personnel to meet the after-care needs of older Americans released from hospitals under DRG's. Where such services are available, coordination of care or linkage with services is often inadequate.

(3) The lack of a well-developed, skilled after-care system in communities is creating unprecedented burdens for the families of affected older Americans. They are themselves unprepared to provide such specialized care—especially on short notice. At the same time, gaps in this system are precipitating an increase in demand for services through the Older Americans Act programs.

(4) Older Americans Act programs can play a number of important roles in responding to these problems, including:

a. Providing accurate information to older persons and their families about the DRG system and their rights under it.

b. Promoting stronger linkages between community supportive services and hospital discharge planners and strengthening case management and advocacy functions.

c. Directing more Older Americans Act resources to the frail and homebound elderly.

d. Strengthening research on long-term care and training for long-term care professionals.

e. Through the long-term care ombudsman program, continuing to monitor the DRG system, investigate and research complaints, and asses the DRG's impact on long-term care.

(5) In order for Older Americans Act programs to "gear up" to meet the accelerated demand for services brought on by the DRG system, funding needs to be bolstered both for Title III nutrition and supportive services, and for Title IV research and training.

## DRG'S: BACKGROUND, INCENTIVES, EFFECTS

AARP is committed both to quality care and to a reduction in health care costs. We supported introduction of the DRG system in the belief that it had the potential to achieve both aims, but an emerging pattern of harm to patients indicates that corrections are needed in the system.

The federal DRG system groups patients by major diagnostic categories. These are further divided by five variables that explain, with an acceptable degree of accuracy, variation in resource consumption as measured by length of stay for different illnesses. This procedure results in 467 diagnostic related groups (DRGs).

The DRG prospective payment system has dramatically changed the incentives to hospitals treating Medicare patients. Under the old "cost-plus" system, hospitals were paid for each service provided. The more services provided, the more money the hospital received. Thus, it was in the hospital's interest to provide excessive services and to keep a patient hospitalized as long as possible. Under DRGs, however, those incentives are gone.

Under DRGs, hospitals have the opposite incentives—to perform fewer services and to get Medicare patients out of the hospital as soon as possible in order to maximize their "profit." Moreover, new administrative rules and policies under DRGs limit Medicare patients' utilization of certain kinds of care and medical procedures.

For example, the Health Care Financing Administration (HCFA) requires Peer Review Organizations (PRO's) to reduce the number of identified procedures performed (the procedures vary from state to state) by specific amounts. PROs will be evaluated by HCFA based, in part, on how well they meet these numerical reductions. For most parts of the country, however, these numbers are based on little or no evidence that the procedures identified can be safely reduced without precluding access to necessary care.

Another example of a government requirement that places Medicare beneficiaries in jeopardy is HCFA's policy directive permitting hospitals to inform Medicare patients before admission, at admission, or during the hospital stay that certain serv-

ices may not be covered by Medicare and that the patient is liable for payment if he or she goes forward with the treatment. This directive is a major new loop-hole in Medicare, and will result in greater out-of-pocket costs to beneficiaries, not to mention the possibility of deterioration in their health if they cannot afford continued treatment.

There are many similar examples, all reflecting the same theme: the incentives inherent in the DRG system, combined with the new rules implementing it, substantially alter Medicare patients' rights under DRGs. This combination of structural incentives and administrative incentives jeopardize beneficiaries in two ways: (1) there is greater jeopardy to individual health status from skimping on services, and (2) there is greater financial liability for services now deemed to be non-covered and for services moved from the inpatient to the outpatient setting where greater cost sharing is required.

Evidence is mounting to demonstrate that patients are indeed sustaining harm under the implementation of this policy:

In February, 1985, the House Select Committee on Aging held a joint hearing with the House Task Force on the Rural Elderly. The subject of the hearing was the quality of care under DRGs. Witnesses testified about problems of early discharge and lack of post acute care services. One witness, a discharge planner for a large hospital in Minneapolis, told about the difficulties she had maintaining hospital care for her sick mother because the small rural hospital claimed her mother's allotted days of care under the DRG had run out. Fortunately, the witness was knowledgeable about DRGs and was able to fight the hospital. Unfortunately, not all Medicare beneficiaries or their families are as familiar with the system and, therefore, are much more likely to acquiesce in the hospital's decision.

On February 26, 1985, the Senate Special Committee on Aging released a report from the General Accounting office on the impact of Medicare's new prospective payment system on post-hospital care. The report showed that Medicare patients run a substantially greater risk of being discharged "quicker and sicker," too often with no place to go.

Just last week, Senator Heinz, Chairman of the Senate Aging Committee, announced that Peer Review Organizations (PRO's) had uncovered some 3,700 instances of inappropriate release or transfer of elderly hospital patients as of March, 1985.

The American Association of Retired Persons is also trying to evalute the scope and breadth of the problems affecting patient care under DRGs. The Association has received over 400 letters and numerous telephone calls from Medicare beneficiaries, their children, nurses, and social workers complaining about poor care and premature discharge under DRGs. In addition, we have interviewed long-term care ombudsmen, Area Agency on Aging (AAA) directors, and State Unit on Aging directors from various regions around the country to obtain their observations. The two stories that follow are illustrative of the anxiety and frustration encountered by Medicare beneficiaries and their families under DRG prospective payment system.

A 71 year old Medicare beneficiary in Texas wrote to AARP about her own unhappy experience. She is a retired registered nurse, with an artificial heart valve, who was admitted to the hospital because of a high temerature caused by an upper respiratory infection. Her artificial heart valve was an additional dimension of concern indicating hospitalization.

After being admitted, she developed problems breathing and was placed on continuous oxygen and inhalation therapy three times a day. The night of her third day in the hospital, inhalation therapy was required for the entire night. In addition, although she was expectorating "thick, purulent matter, tinged with blood," no one at the hospital was concerned enough to investigate.

On the morning of the fourth day in the hospital, her doctor announced she was going home. When she protested, he said that the hospital had a new policy and that they now determined how long a Medicare patient could stay. She writes that her doctor was very upset—even "intimidated' by the hospital. He told her not to fight the hospital. She stated her fears about a relapse or dangerous complications, and refused to go home until her temperature was normal for 24 hours.

On the morning of the fifth day, the hospital's head nurse ordered her to go home and threatened, if she did not leave, to move her to a special floor with no heart or lung equipment and minimal nursing care. For such minimal care, the patient herself was to be charged $65 per day. She was finally discharged the following morning.

After five weeks of recovering at home, she investigated the new Medicare DRG system and learned, among other things, that: (1) the hospital had a medical review board consisting of doctors, nurses, and other hospital personnel, but that, (2) in this

hospital, it is a medical librarian who makes the decisions about how long a patient stays, and that, (3) doctors are pressured to discharge patients as the hospital dictates.

A visiting nurse in rural Iowa reports that, because of utilization review rules, one patient was sent home after hip surgery, despite the lack of adequate after-care at home. The hospital told the patient that they were "not allowed to take the home situation into consideration." Shortly thereafter, the patient pulled a muscle while trying to maneuver around unaided. Hence, the patient had to be sent back to the hospital for treatment.

The latter case illustrates what some observers are calling the "ping pong" effect: because of early release from hospitals, patients are not as well as they should be, and must eventually return due to complications. This phenomenon calls into question the success of cost savings supposedly achieved under the DRG system. Many health care providers suggest that the true result of this approach, in the absence of a developed in-home skilled care system, is simply cost-shifting to Medicaid, to Medicare beneficiaries, and to the patients' families. Worse, under DRG's, many Medicare patients are being discharged from hospitals into a "no-care zone," where they face further deterioration in their health.

A related development reported by some nursing home ombudsmen is that, as patients are referred to nursing homes with acute care needs, they are "bumping" older persons with chronic disabilities from the waiting lists, exacerbating the difficulty of gaining access to scarce nursing home beds for many who are eligible but perceived as less vulnerable. At the same time, many nursing homes find themselves ill-equipped to provide appropriate care for these more vulnerable patients. In response, some nursing homes hesitate to rely on descriptions given by hospital discharge authorities as to the condition of a patient about to be released, and make it a practice to call the floor nurse for more specific details. Such facilities may refuse to accept a patient whose needs they are unable to meet.

### IMPACT ON OLDER AMERICANS ACT PROGRAMS

The primary Older Americans Act programs affected by implementation of DRG systems are Title III-C nutrition services—specifically home delivered meals—and Title III-B supportive services. There is no question but that demand is increasing rapidly for these services as the growing population of frail, very elderly persons is joined by patients and their families reaching out for assistance. But trained help is frequently unavailable.

In New York City, for instance, one of the largest home attendant programs in the country is in operation. But home attendants are not permitted to administer injections or medications, and often cannot provide the level of care required by patients recently released from hospitals. And professionals with appropriate training are in short supply. Still, the types of services that are provided through the OAA are requested more and more frequently, including housekeeping, personal care, chore services, telephone reassurance, and others.

The aging network is hard put to meet these demands. In Denver, a separate, emergency home delivered meals program has had to be created to serve people just out of the hospital; in-home services for such persons are being provided at the rate of almost two hours per day, while the ordinary long-term care consumer continues to receive only two hours of service per week. The trend over the last six months, according to the Denver AAA, has been to provide that intensive level of services with the expectation that, after 3-4 weeks, the individuals will have recovered sufficiently to care for themselves.

Even where appropriate services are available, the turn-around time required for arranging them is often prohibitive. AAA administrators express frustration that discharge planners call and announce the departure of a patient the very next day, and want services arranged immediately. "We can't plan that fast," says one. "We try to work these things out with local agencies in a careful, rational way, but the likelihood of services being made available in an overnight time frame is very poor." The same problem is confronted by families of the patient. As one working woman, told by the hospital of her mother's imminent release, said, "I have no idea what to do with an 85-year old woman with a catheter." Echoing concerns of nursing home ombudsmen regarding access of traditional chronic care clients to nursing homes, some administrators observe that the need to give more attention now to acute care patients is slowing in-home service delivery to chronic care patients.

Complaints and concerns about these problems are coming into the aging network at every level. Older persons and their families, social and medical service providers are calling AAA information and referral services, nursing home ombudsmen, and

Councils on Aging. AARP's discussions with aging network professionals as well as with affected older persons have helped to shape the following recommendations.

AARP RECOMMENDATIONS

While the Older Americans Act programs cannot be expected to resolve single-handedly the complex, multi-institutional problems emerging form the DRG system, a number of important actions can be taken to improve the system's functioning within the community and to alleviate the harm now experienced by older persons.

(A) *Provide accurate information to older persons about the DRG system and their rights under it.*

Administrators and care givers in most (but not all) areas contacted by AARP—as well as older persons who contacted the Association—reiterate that consumers do *not* know about DRG and that "no one out there is educating them." Such education is essential if older persons are to be spared the schock of unanticipated early discharges. Education is also critical to these consumers' ability to assert their rights to a longer stay or an appeal for same when they feel a poor judgment has been made.

AARP, along with other concerned aging organizations, is stepping up efforts to improve older person's knowledge about the workings of the DRG system, but more comprehensive approach is needed. We believe the Older American Act programs can contribute significantly to this educational process.

(B) *Promote stronger linkages between community supportive services and hospital discharge planners; strengthen case management and advocacy functions.*

One of the direct consequences of the DRG prospective payment system is shortened lengths of stay in hospitals. In turn, pressures are developing in the home health service arena as well as in the demand for short-term recuperative nursing home stays. A major problem is that many hospital discharge planners are not fully aware of the wide variety of services available to ease the transition from acute care in the hospital to lesser degrees of care. Quite often, nothing is done at all, and the patient is discharged without any follow-up service. AARP believes stronger linkages between discharge planners and service providers should be developed through various means.

Currently, an information brochure is being developed by the National Association of State Units on Aging in conjunction with hospital discharge planners and nursing home administrators. The purpose is to sensitize these individuals about the availability of services to enable a patient to live in a community setting after leaving the institution. Literature will be distributed to discharge planners to assist them in making contact with service providers. Such literature can also be used for case management purposes to assure that a discharged patient's interests are appropriately served after leaving a hospital. AARP supports this activity. We urge, too, that linkages between discharge planners and the aging services network be expanded to assure more comprehensive and effective attention to the patient's needs.

Case management and advocacy functions also need to be strengthened. Many times, the only real cost savings possible through the DRG system come as a result of effective case management; without it, a patient may be forced into a nursing home prematurely and at twice the cost of maintenance in his own home with home health services. Many AAAs are trying to develop assessment and case management functions based on voluntary interchange and coordination among agencies, but they say "it is a struggle on limited funds."

The importance of the AAA's advocacy function is best illustrated by one experience reported by the Lynn County Council on Aging in Iowa. A local hospital had given notice that a patient who had just undergone cataract surgery could not remain in the hospital under its DRG criteria, but that supervision would be needed at home. Council advocacy resulted not only in extension of that patient's stay by one more night, but in a permanent change in the hospital's policy toward all such patients.

(C) *Directing more OAA resources to the frail and homebound elderly.*

Title III supportive and nutrition services are, in a very real sense, the lifeblood of the Older Americans Act. Over the years, Title III has evolved from essentially a funding source for social service activities to a planning mechanism for developing a comprehensive and coordinated service system for older Americans.

Congress has attempted to give state offices on aging greater flexibility by permitting the shifting of funds between Title III-B supportive services and Title III-C nutrition services. The 1984 Older American Act Amendments, for example, raised the transfer authority from 20 percent to 30 percent over a three-year period. Currently, states can shift 27 percent of the funding between supportive and nutrition services.

AARP urges that state and area agencies on aging continue to promote in-home services for the elderly, including homemaker, home health aid, visiting and telephone reassurance, chore maintenance, and others. These services are crucial to enable older Americans to continue to live independently in their homes. Moreover, in-home services can be valuable for bridging the gap for discharged patients from the acute care in a hospital to other necessary services in a noninstitutional setting.

AARP also wishes to call this Subcommittee's attention to Section 2176 of the Omnibus Budget Reconciliation Act of 1981. Section 2176 describes how states can apply to HCFA for waivers allowing them to set up alternative long-term care services that are home and community based. This project, while fraught with bureaucratic encumbrances, represents a major step forward toward addressing the unmet needs highlighted by this hearing. AARP believes that the Section 2176 programs should be elevated to a permanent Medicaid program to be employed at the option of the states. As an interim measure, we recommend that HCFA meet with appropriate state representatives to streamline procedures for approval and renewal of state waivers. While the Association recognizes that this program does not fall within the jurisdiction of this Subcommittee, we are mentioning Section 2176 because of its potential impact on the problems cited.

(D) *Strengthen research on long-term care and training for long-term care professionals.*

The problems in service delivery and coordination and the paucity of adequately trained providers and skilled facilities strongly speaks for expanding Title IV training, research, and discretionary projects and programs. In particular, trained personnel to provide intensive, skilled in-home services appear to be in very short supply.

A related issue is the need for uniiversal standards for quality home health care, and certification of home health agencies. A state unit on aging director in the South observed that, in response to the increase in need for in-home care, a lot of private markets are being created, including new home health service agencies. The potential for consumer fraud and abuse in this area, as well as in the new field of long-term care insurance, were among concerns he identified.

(E) *Through the long-term care ombudsman program, continue to monitor the DRG system, investigate and research complaints, and actively assess the DRG's impact on long-term care.*

Much of the information AARP obtained about the impact of DRG's on Older Americans Act programs and other parts of the continuum of care came from long-term care ombudsmen who, because of their unique position within the aging network, were able to observe and evaluate many different facets of the situation. The ombudsman can play an invaluable role in providing feedback for planners and policy makers as well as assisting individuals in distress.

(F) *Adequate funding must be provided for in-home services, home-delivered meals, research, training, and demonstrations.*

Adequate funding is essential for services programs, research and training to respond to the needs of older Americans. AARP fully recognizes that we are living in austere times because of the magnitude of the budget deficit. Our policies have been developed in recognition of this fundamental reality. We do believe, though, that modest, well-timed and well-conceived funding adjustments are appropriate under special circumstances.

Such circumstances confront us now. The DRG prospective payment system has generated sizeable savings in hospital and other health care costs. Much of this burden, however, is shifting to the aging services network because discharged hospital patients frequently need appropriate follow-up services. Moreover, the aging services network is asked to assume greater responsibilities because some patients are discharged prematurely.

The aging services network is called upon to assume a greater role, but funding for title III supportive and nutrition services has remained static. Funding for training and research has been cut drastically. We recommend that the Congress develop well-timed and cost-effective adjustments in funding for title III-B supportive services and Title III-C home-delivered meals. The increased appropriation for supportive services should be targeted to in-home services. Similar adjustments should be made in Title IV funding. Both in-house services and home-delivered meals are crucial for older Americans to live independently in a home rather than be readmitted to a hospital or other health care facility. These activities must be adequately funded if they are to fulfill their appropriate mission.

CONCLUSION

AARP has always believed that it is possible both to contain health care costs and to provide high quality health care. We continue in those beliefs. We are deeply concerned, however, that there has not been an adequate effort by HCFA to properly monitor and administer the system and to coordinate contemporaneous policies that appreciate the problematic incentives created by the DRG system. This must change.

In the meantime, vulnerable older Americans, their families, and providers of a broad range of skilled and supportive services will continue to feel the pressures created by these policies. Such pressures, we should note, only exacerbate the effects of our too-slow collective response to radically and rapidly changing national demographics.

That is why the role of this Subcommittee and of the OAA programs is so important. We commend the members of the Subcommittee for calling attention to the problems associated with DRGs, the potential for a constructive response through the Older Americans Act, and the need to plan fully and carefully for larger changes related to this demographic shift in the years ahead. The AARP stands ready to work with you in anticipating and preparing for these changes.

Mr. KILDEE. Thank you very much, Mrs. Ostrander. Are we really saving dollars or merely shifting these costs either to older persons or families or even to other agencies?

Mrs. OSTRANDER. This is the question that needs to be answered, because we see that there is a definite shift to older Americans, but there is also a shift to other programs such as Medicaid.

I think those of us that have worked very closely at the State level—and I think you've heard some of the State people here today—can tell you that they are seeing that shift in both areas.

I think we have to be very realistic, because in one area—and you've zeroed in on it with a previous speaker—when a hospital informs a patient that beyond a certain point they will be responsible for the cost, some patients who absolutely have no understanding of their rights under DRG's will accept that and willingly pay for it, or as a hospital begins to branch out into additional services, even though they may or may not put the ability to pay system, as we heard the hospital that testified this morning, that means that in many instances that individual, unless they qualify for Medicaid, will be paying that additional cost out of pocket.

Mr. KILDEE. Do you know of any cases you can bring before this committee of individuals who had to be sent back to the hospital because they were discharged too early under the DRG system?

Mrs. OSTRANDER. I wish that your counterpart from Iowa were here, because in our full statement you will find a case of a woman with hip surgery that was sent home without adequate preparation at home, no capabilities to deal with that, and she ended up having a secondary situation develop that turned around and put her back into the hospital.

In other words, we have created a ping-pong effect, or, as some areas of the country have said to us, "Well, we have had to take so-and-so back to the emergency room because they were not prepared at home," such as a cataract patient who had absolutely no one at home to deal with them. So they end up maybe falling because they can't see.

These are the areas that we have to be really conscious about. Are we really saving money, or are we adding to the system by readmission for another condition?

Mr. KILDEE. Let me ask the question that I asked the hospital administrator. Do you think that the decision to discharge a patient, say, after 10 days is going to be more fiscal than medical under the DRG system? Do you think that the DRG system almost tempts hospitals to make fiscal decisions rather than medical decisions?

Mrs. OSTRANDER. Yes; I think we're seeing more of that, and that's the realistic part.

We have to place the responsibility where it belongs. The responsibility for discharge should be the physician's; it should not be the hospital's. But, unfortunately, as we have heard, hospitals are concerned about their fiscal stability.

Therefore, under the DRG system, we find that more and more of the hospitals are making the decisions on a fiscal basis rather than whether or not it is in the best interests physically for that patient, and I think one of the areas that we all must aggressively work on is to sensitize the physician that he or she must assume a leadership role in the care of that patient, starting from the first day of admission.

Mr. KILDEE. Do you think that hospitals in general, or many hospitals, take advantage of the patient's lack of knowledge of the DRG system—that they don't fully inform them and, as a matter of fact, sometimes almost withhold certain facts from the patient when they come in and give them the news that they must leave?

Mrs. OSTRANDER. You have to go back to the fact that my generation accepts the authority figure of doctors and hospitals. Assuming that, you will find that most of that group have not in the past known how to challenge the system, how to ask questions.

Therefore, it has been easy to take the patient, the beneficiary, and pretty much say to them, "Well, your time is up, and this is what the law says." Because that individual is not knowledgeable—and I think this is one of the biggest areas of responsibility we all must assume; I know AARP is attempting to move in—how do we educate that beneficiary so that what you are asking me does not occur—that it does not put the hospital in the position of being able to tell the beneficiary, "Your time is up," and that beneficiary accepts that.

Some of my very well educated friends that I thought could read and understand things as I did, I am surprised at their acceptance of hospital mandates, so to speak, and they have not challenged them in the interests of their families.

Mr. KILDEE. Do you know what actually happens? Say a hospital says, "OK, day No. 10; that's it; you must leave," and the attending physician wants the patient to stay longer. What takes place in that conflict there? Is the doctor under some pressure from the hospital?

Mrs. OSTRANDER. We have heard in some cases where a doctor has been able to bring his responsibility into play and been accepted by a hospital, but we have also heard the opposing view from some physicians who have said that hospitals have monitored their record in terms of whether they are creating enough profit for the institution or whether they are creating losses for the institution. So there is a mixed situation there.

We hope in the future, as we work more and more with the physician community, that we can sensitize the physicians to again pursue the leadership role. But remember, that staff position for the physician is important, and that staff physician is not going to want to lose that staff privilege.

Mr. KILDEE. Do they feel that their staff privileges are in jeopardy if they consistently disagree with the hospital?

Mrs. OSTRANDER. There is no question about that. That could put them in jeopardy. I think physicians, just like anyone else, would react if it impacts on them personally. They would like to retain privileges, especially where there is only one hospital in the community.

Mr. KILDEE. You mentioned cases where a person's mother was being discharged and there was no room in the nursing home. If we provided, say, more home service type programs, might there be more room then for people being discharged to go in that transition stage into the nursing home?

Mrs. OSTRANDER. I think you have to provide a mix of things here. You will find that there should be some way in which we can fill that gap with some form of service.

I think you will find in our full statement some unique innovations in the area in Denver about giving priority to an emergency meal set-up and transition type thing.

Then also we have to look at, as the population ages, where you get more and more frail elderly, that frail elderly person must not only have the availability of community-based services if they are needed but also the beds if they are needed in a nursing home, at least for a period of time.

Mr. KILDEE. I look at the appropriations for home-delivered meals. In fiscal year 1984, it was $67 million and then in fiscal year 1985 $67.9 million—really not much growth at all—and yet the demand for that type of program certainly must be growing, is it not?

Mrs. OSTRANDER. I can tell you some very interesting things in my own home State, because I have been very actively involved with the State agencies and the AAA.

Because of that lack of growth there and the need growing, they have re-established new formulas in order to better target, say, some of the very poor elderly and the minority elderly in the rural areas. This has played havoc with the urban areas who still are faced with a very serious problem of increased numbers of elderly.

So the question is, what do you do, rob Peter to pay Paul? You aren't really accomplishing a great deal. You might be providing a little bit better service to those that perhaps did not get it, but in essence you have then created another gap back into another area. So it is really creating some tough financial decisions for the network to deal with the needs in their own areas.

Mr. KILDEE. That's a good point, because I think very often there are some people who are not really in poverty but are in need of that type of service.

In other words, they could actually pay for part of it or pay for the meal coming in, but they need the assurance that at 11:30 today someone is going to come by with that meal. They might not be in poverty, but they are in need of that service.

I think very often, as we don't increase the appropriations, there's a tendency to try to take care of those with the most acute need but missing those who still have need even though not in poverty themselves.

Mrs. OSTRANDER. And even in the congregate sites, many of the older women who live alone would not eat properly if they had to eat alone, and I think you would have a ripple effect of problems developing down the line if you did not have adequate funds for nutrition sites.

So you have to look at that total program—what is it doing for all of the elderly in that community.

Mr. KILDEE. I want to thank you for your testimony today. We look forward to working with you. This subcommittee has great admiration for your association. You really have a great reputation here on the Hill. You always provide us with very, very reliable data, which I think is one of the reasons that you do have that great deal of respect here. I want to thank you and thank all of our witnesses.

The record will stay open for 10 additional days for any further submissions for the record.

Mrs. OSTRANDER. We appreciate it.

Mr. KILDEE. Thank you very much.

[Additional material submitted for the record follows:]

EKCO PRODUCTS, INC.,
*Wheeling, WV, August 26, 1985.*

Hon. DALE E. KILDEE,
*Chairman, Human Resources Subcommittee,*
*House Committee on Education and Labor,*
*Washington, DC.*

DEAR MR. KILDEE: This letter is written to comment on the July 30, 1985 hearing, "Impact of Medicare's DRG Implementation on the Need for Services under Title III of the Older American's Act."

As marketing manager for elderly nutrition programs, I travel around the country visiting meals-on-wheels and congregrate nutrition programs. I strongly believe the elderly nutrition programs are one of the most worthwhile federally funded programs. The facilities I have visited have been very efficiently and professionally run, yet, there are still thousands of starving elderly people living off of tea and toast due to lack of funding for congregrate and meals-on-wheels programs.

Moreover, as a registered dietitian with over ten years experience in hospital and nursing home foodservice, I know the role good nutrition plays in health. In fact, malnutrition can lead to unnecessary costly hospitalizations. When I worked in a hospital and nursing home, I saw countless cases of malnutrition in the elderly.

Because DRG's have reduced patient hospital days, elderly patients are being sent home "sicker and quicker". Using myself as a personal reference (single, living alone), I would find it difficult to prepare meals after a hospitalization. I can not imagine the difficulties a 77 year old woman would have in this situation.

If the federal government is committed to curbing health care costs through DRG system, then they must be committed to providing funds for post hospitalization meal services. This should not be at the expense of the congregrate and meals-on-wheels programs. For many, the meal eaten through these programs, is the elderly person's only daily meal. Taking meals away from these programs to provide meals for newly discharged hospital patients unable to cook, will only lead to more problems.

Good nutrition is vital to the health and well being of our rapidly expanding elderly population.

Please give consideration to my honorable suggestions.

Sincerely yours,

SUSAN M. KOUKOL, R.D., *Marketing Manager.*

AREA AGENCY ON AGING, INC.,
*St. Joseph, MI, August 2, 1985.*

Ms. SUSAN A. WILHELM,
*Staff Director, Subcommittee on Human Resources,*
*Committee on Education and Labor,*
*Washington, DC.*

DEAR MS. WILHELM: It was a pleasure to be invited to testify on behalf of the nation's Area Agencies on Aging on the issue of the Medicare DRGs and the Older American Act. It is most gratifying to know that some members of Congress, such as Mr. Kildee and Mr. Tauke, are deeply concerned about the well-being of the at-risk elderly, a group increasingly vulnerable under the DRGs.

During the course of the hearing, Congressman Kildee inquired about possible conflict between hospitals and physicians and about the role of the Peer Review Organizations. Attached are copies of articles from the *Wall Street Journal* which discuss these issues. I thought the Congressman might find them informative.

Your and Ms. Wright's fine efforts in planning the hearing were evident in both the logistics and the substance of the session. They were most appreciated.

Sincerely,

ROBERT L. DOLSEN, *Executive Director.*

HOSPITALS AND DOCTORS CLASH OVER EFFORTS BY ADMINISTRATORS TO CUT MEDICARE COSTS

(By Jennifer Bingham Hull)

Hospitals have started using sophisticated computers to generate profit/loss statements on doctors, to compare physicians with their peers and to target so-called "overusers"—those doctors whose Medicare patients cost the hosptial too much money.

Predictably, some doctors have reacted with anger and fear to the new cost-monitoring made necessary by a major change in Medicare. As the new system, called "prospective payment," is phased in around the nation, Medicare will no longer pay all doctor-ordered medical costs for 23 million eligible elderly Americans. Instead, Medicare will reimburse at fixed rates for designated medical problems.

Hospitals that provide treatment under the fixed rates can keep the change. Those that exceed the rates have to absorb the extra costs themselves. Because doctors determine most hospital costs by prescribing tests and other forms of treatment, they are coming under new pressure to be cost-conscious.

"We're not only on the front line telling the patient to go home and getting all of that abuse, but we have to pick up the liability if a mistake is made," says William Plested, chief of staff at Santa Monica Medical Center in California. "The initial result is going to be conflict between the administrator and the physicians because the hospital has been put in the position of policeman."

CLASHES OVER LIABILITY

John Koury Jr., a surgeon in Port Huron, Mich., who is chairman of the American Medical Association board of trustees, says it is too early to judge how the new system will affect relations between hospital administrators and physicians. But he predicts clashes over questions of liability and malpractice.

On the other hand, the American Hospital Association supports prospective payment. Its president, J. Alexander McMahon, doesn't expect confrontation, he says, and he makes one of the arguments for the new system by saying: "We all know there has been extra testing going on because under cost reimbursement the idea was if you can do it, do it." The new system is an attempt to ease Medicare's cost crisis. The Congressional Budget Office said earlier this year that hosiptal costs attributable to Medicare patients would grow by more than 13% annually through 1995, with the system piling up deficits that could total $310 billion by that year.

Dr. Koury rejects any suggestion that the Medicare funding crisis can be attributed to doctors. "The Medicare problem was developed by the government because they over-promised and under-funded, and now they're trying to blame hospitals, physicians and the public for the problem they created," he says.

Doctors' fees aren't covered by the new system, although the government is considering including them. So, the incentive to limit treatment is entirely with the hospital. Cutting costs just reduces doctors' incomes.

Some administrators are unhappy about their new policeman role. "It's just unreasonable, irrational and unstable to have a system where the physician's incentive

is in one direction and the hospital's incentive is in the other," says Richard Norling, president and executive director of California Hospital Medical Center in Los Angeles.

But, with 40% of the average hospital's revenue coming from Medicare, administrators are warning that hospitals will go bankrupt without physicians' cooperation. They are telling doctors that new equipment won't be purchased if they are losing money; that certain expensive procedures may be eliminated and that staff privileges of physicians who overuse resources may be revoked.

Santa Monica Hospital, which gets 60% of its revenue from Medicare, is changing departmental rules to limit the non-reimburseable treatment physicians do. Leonard LaBella Jr., president, says overusers will be tolerated for about six months before privileges to perform certain treatments are reviewed. (Prospective payment began in some hospitals Oct. 1 and is being introduced around the nation as hospitals start their new fiscal years.)

Restricting doctors for cost reasons is highly controversial and legally untested. Experts expect legal challenges if staff privileges are terminated on economic grounds. Doctors are also alarmed that the new system may leave them more vulnerable to malpractice suits.

"We're concerned about the necessity to discharge a patient as soon as possible," says Alfred Alessi, an AMA delegate from New Jersey who has lectured across the country on the new system. "If you have a relative that goes home before you want them to, you don't blame the hospital, you don't blame the government, you blame the doctor. The doctor becomes the bad guy."

Many administrators are relying on doctors to help them curb overusers. Peer pressure, from physicians assigned to monitor and counsel their colleagues, proves effective because doctors don't like to deviate from colleagues' norms, experts say.

There are indications that doctors are cooperating, although it is still too early to see clear effects of prospective payment. The average length of stay at hospitals across the country has dropped since last summer—some experts say because of doctor response to the Medicare change. "Doctors seem amazingly willing to take the long view of this thing," says Jeff Goldsmith, a consultant with the Cleveland-based accounting firm Ernst & Whinney who has lectured physicians about the new system.

New Jersey has had a similar reimbursement program for three years, and Paul Cooper, administrator of the Bridgeton Hospital in Bridgeton, N.J., says conflicts surface constantly. The hospital tells doctors to reduce the lengths of patient stays, but doctors are liable if problems result from early discharges. Physicians want to use a new drug, but hospitals may discourage its use because of cost. Doctors accused of being overusers tell Mr. Cooper that they're protecting themselves against malpractice accusations. Mr. Cooper says a doctor cited a colleague who had been sued for skipping one test.

Despite doctor opposition, Mr. Cooper says, many physicians have reduced patients' stays. "We've had resistance, but when push comes to shove they come around," he says.

One doctor labeled an overuser is John Madara, 62 years old, a family physician in Salem, N.J. Dr. Madara was head of a committee reviewing doctor use of procedures at Salem County Memorial Hospital when the hospital issued a list of the top ten users of resources. He was on it.

Dr. Madara was called into President J. Michael Galvin's office and shown computer printouts comparing his costs with those of his peers.

### GETTING YOUR HAND SLAPPED

"I tried to tell him that my practice is getting older with me, that I have a lot of . . . patients who are hard to get out of the hospital and that 90% of my admissions are acute admissions," Dr. Madara says. But, he says, Mr. Galvin said, "'Well, other physicians seem able to do it.'" Dr. Madara says he felt badly—"It's like getting your hand slapped"—and is changing his ways. He recently discharged a pneumonia patient after three days rather than the usual six. "The hospital will love that. But the reverse side is that I'll be paid for three days instead of six." He says his hospital-based income has decreased under the New Jersey system.

Mr. Galvin says the session with Dr. Madara was educational rather than confrontational.

As the system takes effect, patients are likely to be confused. Charles Krueger, a physician in Mount Holly, N.J., often finds himself explaining reimbursements to patients. "Someone recovering from surgery says 'Gee, Doc. it still hurts to walk,' but has no complications. I say, 'It would be nice if I could keep you in the hospital,

but it's not between you and me anymore, Buddy,'" says the doctor. "We have a system that says you have to leave."

## For Hasty Release of Aged Patients

(By Jennifer Bingham Hull)

In Michigan, the family of an ailing, 87-year-old woman is told she must be discharged from the hospital because her Medicare payments have run out. In Oklahoma an elderly man is released from a hospital even though his physician believes he needs more care. And in Maine a 73-year-old man is sent home despite pleas from his family that he stay in the hospital.

Each case reflects a growing criticism of Medicare's new method for reimbursing hospitals: the use of diagnostic-related groups, or DRGs. The system, begun in late 1983, sets a fee for 468 DRGs or health problems, thus encouraging hospitals to treat patients quickly. If the patient's treatment costs less than the rate set for his particular ailment, the hospital pockets the savings; if the patient's treatment costs more than the set rate, the hospital picks up the difference.

In the fiscal year ended last Sept. 30, the average hospital stay for a Medicare patient dropped to 7.5 days from 9.5 days in fiscal 1983. Supporters of DRG-based payments say shorter stays cut costs and help patients avoid hospital risks like infections. Quality of care, they add, hasn't suffered under the new system.

But some government officials and doctors say the system is prompting hospitals to discharge patients permaturely or to tell them, erroneously, that they must leave the hospital because their federal payments have run out. Additionally, critics say, quick discharges leave the elderly with another problem: finding health care outside the hospital. Nursing homes are full, and home-health services are often inadequate.

### NO-CARE ZONE

Patients "are being sent to a no-care zone," says Sen. John Heinz (R., Pa.), chairman of the Senate Special Committee on Aging.

Finding fault is difficult. Doctors say hospital administrators are pressing them to release patients early. Hospital administrators say only doctors can decide when to discharge patients. And both groups say the federal bureaucracy has created a system that is, at times, unnecessarily rigid.

Meanwhile, say critics of the payment program, patients are mistreated and endangered, and their families are confused. Last July, for example, Gladys Roteman, 88 years old, was admitted to Lapeer County General Hospital in Michigan. Mrs. Roteman was diagnosed as having congestive heart failure, which calls for about seven days of Medicare payments. But implications kept the woman in the hospital for almost a month, and the hospital had to absorb the extra cost.

At the end of that month, according to Mrs. Roteman's family, a hospital social worker, Jackie Zdenek, told them that Mrs. Roteman would have to be discharged because the payments for her ailment had run out.

After making 65 calls to local nursing homes, the hospital finally transferred Mrs. Roteman to the only facility that would accept her—200 miles away. Relatives found it difficult to reach the nursing home and didn't even learn that she had suffered a stoke soon after arriving until several says after it had happened.

"None of us were by her side when she died" in the nursing home in November, says Dawn Lietke, Mrs. Roteman's granddaughter. "I think the whole system is pretty crummy."

A hospital spokesman says that patients aren't discharged because their Medicare payments expire and adds that Ms. Zdenek is confused about how the system works. But Ms. Zdenek says: "That is the normal way we do it."

Mrs. Roteman's physician, Jeffrey Harris, says that although his patient had numerous problems, there was nothing more the hospital could do for her. While acknowledging that the nursing home was impractical, he says that the scarcity of nursing home space and the pressure in hospitals to release patients mean the solution "right now . . . is any place they can get them in, within reason. It's a big problem."

The establishment in each state of peer review organizations, or PROs, to police the Medicare program, further complicates the discharge issue. The federally finance groups generally set standards for admitting and releasing patients. They can also punish doctors and hospitals who fail to comply with those standards by removing them from the Medicare program. Some doctors are running scared.

In January, Floyd Lane, 82, was admitted to Henryetta Medical Center in Henryetta, Okla., with a urinary-tract infection, pneumonia and chest pains. After two

weeks, he was sent to a local nursing home but was rushed back to the hospital two days later. He died soon after arriving in the emergency room.

"I wish I had kept him in (the hospital) longer," says the physican who released Mr. Lane. The doctor, who asked not to be identified, says Mr. Lane would have benefited from further hospitalization because of his poor condition and apparent history of heart problems. But he says the patient was eager to leave and didn't meet the state PRO's new criteria for continued care. The doctor adds that he feared being punished by the PRO if he had kept Mr. Lane in the hospital while those criteria weren't being met.

A spokesman for the Oklahoma PRO says the group's standards are only guidelines and that a doctor can't be punished for keeping a patient too long. But the spokesman says PROs can punish doctors and hospitals for admitting patients who don't meet PRO criteria or for discharging patients too soon.

Indeed, PROs across the country are investigating the practices of hundreds of doctors who allegedly discharged patients too early or violated other PRO standards, says Philip Nathanson, director of the Bureau of Health Standards and Quality for the Health Care Financing Administration, which administers the Medicare program.

But staff members at Henryetta Medical Center say PROs aren't clear about what actions are punishable. And the hospital's administrator, James Clough, questions whether PROs are really concerned about premature discharges. "The government has mandated that the physician will be the executioner," he says, "and told him if you won't use the sword to cut back services from the elderly we will cut off payment from you."

That argument may sound familiar to Carmen Lajoie of Lewiston, Maine. Last September, her husband Antonio, 73, was almost discharged from the Central Maine Medical Center in Lewiston after a three-day stay for dehydration. Hospital personnel explained that Medicare covered only three days of care for his diagnosis.

### UNABLE TO WALK

Family members delayed the move, arguing that Mr. Lajoie, who had been unable to eat or get out of bed, needed further care. But on the fifth day, Mr. Lajoie "was told . . . that if he couldn't stand up and be sent home by car, he would have to be sent home in an ambulance—which is how he went," says Elaine Francoeur, the Lajoie's daughter.

Two ambulance attendants were needed to get the 170-pound patient into his bed at home. Mrs. Lajoie says she had no idea how to care for him. In that first week, to try to walk, Mr. Lajoie wrapped his arms around his wife's neck and she pulled him out of bed. During one such effort, both collapsed, and Mr. Lajoie refused to walk again. He was afraid of hurting his wife, and she refused to see a doctor to check for possible injuries.

"She was afraid there would be no one to take care of my father," says Mrs. Francoeur. At that point, the daughter and her husband took Mr. Lajoie into their home.

Mrs. Lajoie complained to the hospital about her husband's treatment. In January, she received a letter from Frederick Gleeson, the doctor who treated him. Referring to the hospital's inability to arrange further care for Mr. Lajoie, Dr. Gleeson wrote: "I feel these decisions were out of my hands and were predetermined by the medical care system." Both Dr. Gleeson and hospital administrators decline to discuss the case.

Mr. Lajoie died in March.

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### Revolution in Cost of Health Care

The U.S. is in the midst of the revolution in health care finance, the third since the end of World War II. First, there was the extraordinarily rapid diffusion of private health insurance between 1945 and 1960: The number of people with hospital insurance rose to 122 million from 32 million, and the number with physician-expense protection soared from fewer than five million to more than 83 million. The second revolution occurred in 1965 with the creation of Medicare and Medicaid. This stroke of the pen provided substantial health insurance to additional millions of Americans among the elderly and poor.

Widespread private and public insurance contributed to the explosion of health-care costs. The primary goal of the current revolution is to contain those costs. It began tentatively in the late 1970s with a few states experimenting with regulation of hospital reimbursement. The movement accelerated in the early 1980s as both the private and public sectors embraced large-scale, radical alterations in the reim-

bursement of hospitals and physicians. Medicare's prospective payment system based on diagnosis-related groups, the state of California's hospital-specific contracts for Medi-Cal patients, the increasing use of deductibles and coinsurance, and the spread of health-maintenance organizations and preferred-provider organizations are among the best known symbols of this new era in health-care finance.

The first two revolutions increased the demand for medical care, regularized payment and promoted greater equality of access, while posing no threat to the traditional organization and delivery of care. Private insurance companies were loath to challenge the behavior of physicians or hospitals, and the Medicare and Medicaid legislation stated specifically that there was to be no interference with traditional practice. The current changes in finance and reimbursement are strikingly different. They are having and will continue to have revolutionary effects on hospitals, the practice of medicine, medical education and medical research.

The recent focus on health care costs stems from four sources. First, the slow growth of the U.S. economy in the late 1970s and early 1960s was not accompanied by an eqivalent slowing of health spending.

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Third, the large role played by third-party payment has raised doubts whether the benefits to patients from additional spending are equal to the cost to society of providing the additional care. When consumers pay for goods and services directly they tend to balance the costs of what they buy against the benefits they expect to receive. When insurance is present, however, the patient will want and the responsive physician will recommend care even when the cost to society exceeds the benefit to the patient. A fourth reason for the changes in health-care finance is that the country is currently in a pause or even a retreat from the thrust toward a more egalitariahn society. Some, but not all, of the cutbacks in funding and changes in method of reimbursement reflect a weakening of the commitment to provide high-quality care to the poor.

Each attempt to contain costs has its own special thrust, but there are a few features that are common to most of the new methods of finance and reimbursement. First: the changes are typically designed to lower costs for specific payers (e.g., the Medicare program, the state of California, the XYZ corporation), rather than system-wide containment. Second, payment for individual tests, visits, days in hospital and the like are being replaced by a global payment (one fixed payment) for all illness episode, a hospital admission or for a year of care regardless of services used.

Third, reimbursement rates are set prospectively rather than retrospectively. The buyers of care no longer want to pay retrospectively based on cost; they want to know in advance what the price will be. Finally, consumers must make more choices and accept more financial responsibility for their choices. In the past, many employers offered a single health plan to their workers. Now it is not unusual for employees to choose among conventional reimbursement insurance, a prepaid group plan, a preferred-provider plan, and still other forms of payment and organization. Moreover, within the conventional reimbursement mode, consumers frequently must choose the size of the deductible and the percentage of coinsurance.

Action on health-care spending was long overdue, but the current preoccupation with cost may result in other problems, especially with respect to health and access to care. The pressure to be more economical in the provision of care will force physicians to make decisions that may be contrary to the best interests of individual patients even though they may make a great deal of sense from the viewpoint of society as a whole.

The need to compete vigorously through price and service may lead hospitals and physicians to abandon the open, collaborative behavior of the past. Physicians in one group may become reluctant to share information with physicians in a competing group. Hospitals may become unwilling to make data available that could give a competitive advantage to another hospital.

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Competition in health insurance markets, and the efforts of each individual and company to obtain the best possible value, will hasten the demise of community rating of health insurance premiums. In the past, heavy users of care were, in effect, subsidized by those who used less health care. The ethical dilemma is clear. On the one hand it is socially desirable to reward healthy behavior and efficiency and to punish excessive use of care. On the other hand, the fragmentation of insurance markets will mean very high premiums for some groups and the abandonment of collective responsibility for health care.

Every revolution carries within it the seeds of its own destruction through excessive pursuit of one goal. The present revolution in health care finance is no excep-

tion. The problems it addresses are palpable: over-utilization of medical services, inadequate evaluation of new technologies, inefficient and inequitable cross-subsidization, and excess supplies of specialists and hospital beds. But the problems it may create are also significant: inadequate insurance coverage for millions, erosion of professional ethics as an instrument of control, loss of trust between physicians and patients, and a decline in medical research. The new challenge is to capture and preserve the benefits of the revolution while minimizing its costs.

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THE AMERICAN DIETETIC ASSOCIATION,
*Chicago, IL, August 29, 1985.*

Hon. DALE E. KILDEE,
*Chairman, Subcommittee on Human Resources,*
*Committee on Education and Labor,*
*Washington, DC.*

DEAR CHAIRMAN KILDEE: This represents the views of the American Dietetic Association (ADA), the national organization for more than 50,000 nutrition professionals, on the above referenced hearing topic. We commend your Subcommittee for recognizing the importance of its oversight function in this area, and would appreciate it if you would accept this letter as testimony for the record and include it in the published report of the July 30 hearing.

Registered dietitians across the nation are observing deleterious effects on patients since the implementation of Medicare's prospective payment system based on diagnosis-related groups (DRGs). As the impact of DRGs on both patients and providers intensifies, dietitians are designing studies to measure the effect of DRGs.

A summary of current data collected by ADA members follows. These data support the July 30 testimony of the National Association of Nutrition and Aging Services Programs (NANASP). The essence of NANASP's testimony was to verify that the impact of DRGs on Older Americans Act (OAA) Title III programs has been "immediate and dramatic," and to express the need for "resources to hold up our part of the bargain in providing long-term care."

Additionally, the following data support ADA's historical concurrence with the recommendation to increase appropriations for Titles IIIb (and target these funds to in-home services), IIIc2, and IV. This recommendation was made by the American Association of Retired Persons in its July 30 testimony.

WASHINGTON STATE

An increase of 33% in rural areas and 24% in urban areas of persons receiving home-delivered meals is reported in an Eastern Washington Area Agency on Aging study comparing data from the third quarter of 1984 with those of one year earlier. Local home health agency estimates of increased home visits since the advent of DRGs were used to determine the percent of DRG-caused home-delivered meal recipients. One of every four clients served by the rural and urban meals programs during the first seven months of 1984 needed this service because of DRGs.

A new trend of short-term meal assistance—clients who receive an average of 10 meals over a 2-week period, then move off the program rolls—was reported by the Spokane nutrition program director. "These people, when discharged from the hospital, are quite ill, cannot prepare a meal and need some temporary assistance, after which they become well enough to prepare their own meals, go onto the Chore Program or experience a relapse and return to the hospital. . . . This new development of short-term meal assistance is definitely attributable to DRGs."

Demand for delivery of therapeutic diets to homebound elders increased 168% from July 1983 to July 1984, according to records of the Spokane Valley Meals-on-Wheels Program. The records showed that 44% of the 1984 clients had been early releases from area hospitals, compared to 0% in 1983.

In this study, the typical home-delivered meal recipient discharged early from the hospital was an 80-year-old woman who lived alone and had an income below poverty level.

FLORIDA

The state nutritionist in Florida confirms that all programs are receiving substantially more requests for home-delivered meals, particularly for short-term clients discharged from the hospital early.

Manatee County (south of St. Petersburg) reports a 35% increase in demand for home-delivered meals over the past year, and attributes all of the increase to DRGs.

Funds that would normally be used to get long-term clients off the waiting list for home-delivered meals must be used for emergency short-term service. Although this program is substantially supported by private funds, these resources are being stretched to the limit.

Meal service has been a critical factor in ensuring early-discharge clients' well-being—and, in some cases, their survival. Often, the only person who checks on these clients is the one who brings their daily meal. Any problems observed are immediately reported to the home health service.

But many clients are unable to receive adequate care after discharge, so their condition deteriorates, secondary complications arise, and they are readmitted—frequently to the ICU or CCU instead of the general medical or surgical ward. So a system that was designed to save health care dollars appears—at least in some instances—to be costing more dollars.

Renal diets, sodium-controlled diets, and other special diets are in great demand in the Orlando area. Because the regional kitchen does not employ a dietitian, Osceola County is trying to negotiate an arrangement with an area hospital to procure special-diet meals from the hospital. These meals will cost $4 to $5 apiece, compared with the regional kitchen's per-meal cost of $1.80.

KANSAS

The nutrition spcialist from the Kansas Department on Aging reports that home-delivered meal service has increased 57% from 1982 to 1984, while congregate meal service increased just 10% over the same period. Both Title IIIc2 and state-funded nutrition programs reported sizeable increases in referrals from hospital discharge planners and community agencies beginning in late 1983—when DRGs took effect.

Some rural hospitals (e.g., in Ottawa, KS) have dropped their sponsorship of small Meals-on-Wheels programs—which are typically operated at a loss—because of revenue loss under the DRG-based system. These factors have increased not only the demand for service, but also the demand for a higher level of service—such as modified diets and 7-day service. The Kansas state legislation appropriated additional funds to attempt to meet this demand.

MARYLAND

Maryland is operating under a DRG waiver—but the nutrition program director in the Office on Aging notes that many hospitals are treating patients as though they were covered under DRGs. Inappropriate outpatient surgery and inadequate discharge planning exacerbate the problem. The scenario is the same as in Florida: Many people are sent home without adequate support systems; the person delivering meals may be the client's only contact with the outside world; and, not surprisingly, many former patients are being readmitted quickly in a more serious condition than when they were discharged.

Maryland is unable to meet any new demand for home-delivered meals because it is operating at peak capacity with the resources available. Programs with private funding attempt to fill the gap, but have limited success. This situation may contribute to the high rate of hospital readmissions—another example of DRGs costing instead of saving money.

IOWA

In one area of Iowa, demand for home-delivered meals has actually decreased—because hospital discharge planners aren't referring patients to the program. More surgeries are being performed in physicians' offices, where there are no referral systems in place.

OTHER STATES

California, New York, and Pennsylvania are among the states from which ADA's technical experts on this issue—the Gerontological Nutrition and Consultant Dietitians in Health Care Facilities Dietetic Practice Groups—are expecting additional data. If your Subcommittee conducts additional hearings on this subject, we hope you will invite us to share new information at that time.

Should you desire clarification of this statement or additional information, please call me at (312) 280-5010.

Thank you for the opportunity to share these concerns for the record.

Sincerely yours,

JULIAN HAYNES, Ph.D., *Executive Director.*

[Whereupon, at 12:05 p.m., the subcommittee was adjourned.]

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